FORM – HIPPA RELEASE FORM

Kimberly-Clark Corporation Group Health Plans/On-Site Medical Facilities
Authorization For Release Of
Protected Health Information

You have the right to authorize the group health plans sponsored by Kimberly-Clark Corporation (the "Plans") or a Kimberly-Clark Corporation on-site medical facility or personnel ("Health Care Providers") to disclose your protected health information to third parties by completing this form. You are not required to complete this Authorization unless you desire to agree to such disclosure.

SECTION 1 – INDIVIDUAL INFORMATION

Please provide the following information about the individual who is the subject of the protected health information.

Individual's name: _____
Individual's social security number: _____

Individual's address: _____
_____
_____
_____
_____

SECTION 2 – PLANS OR HEALTH CARE PROVIDERS

Please identify the Plan(s) and/or Health Care Provider(s), as applicable that are authorized to disclose your protected health information. Please check each that apply.

- ☐ On-Site Medical Facility or Personnel located in _____
- ☐ Medical Plan (includes prescription drug)
- ☐ Dental Plan
- ☐ Vision Plan
- ☐ EAP (Employee Assistance Program)
- ☐ Medical Flexible Spending Account Plan

SECTION 3 – INFORMATION TO BE DISCLOSED

Please complete this section.
I hereby authorize the above-referenced Plan(s) and/or Health Care Provider(s) to disclose to:
Name: RECORDS DEPOSITION SERVICE, INC.
Address: PO BOX 5054, SOUTHFIELD MI 48086-5054
REQUESTS@RECDEP.COM
FAX: 248-357-3337
Telephone Number: (248)357-3330

the following protected health information: *[Describe, in as much detail as possible, the protected health information that you wish to be disclosed. For example, the type of claim, the date of treatment, the type of treatment, etc. You may attach additional pages if necessary.]*

_____

_____

_____

The purpose of the disclosure is:

- ☑ For use in a judicial or administrative proceeding
- ☐ Other: _____

This Authorization expires:

- ☐ One year from the date of this authorization
- ☐ Other [describe date or event]: _____

SECTION 4 – AUTHORIZATION AND SIGNATURE

By signing this Authorization:

- You understand that you may revoke this Authorization at any time by sending a written notification on a form provided by the Plan(s) or Health Care Provider(s) to the address listed below, and that such revocation will be effective only for future uses and disclosures of your protected health information. However, you further understand that this revocation will not be effective for information that the Plan(s) or Health Care Provider(s) have already used or disclosed by relying on this Authorization.
- You understand that your ability to receive treatment, enroll in the Plan(s), or become eligible for benefits is not conditioned on your signing this Authorization.
- You understand that if the recipient of your protected health information is not a health care provider, a health plan, or a health care clearinghouse, the information to be disclosed may be re-disclosed by the recipient and no longer subject to the protection of the Federal Privacy Regulations.
- You understand that you hereby authorize the disclosure of your protected health information as described in this Authorization.
-

Signature of individual*: _____

Date: _____

**If the request is being made by the personal representative of the individual, no signature is needed in Part 4. Please complete Part 5.*

SECTION 5 – PERSONAL REPRESENTATIVE INFORMATION AND SIGNATURE

If you are completing this Authorization on behalf of the individual who is the subject of the protected health information involved, please check the applicable box explaining your authority to act on behalf of that individual, provide the information requested and sign below:

- ☐ Parent of a minor child
- ☐ Pursuant to an authorization*

☐ Pursuant to a court order of guardianship*
☐ Pursuant to a power of attorney*
☐ Other*: _____

* Please attach a copy of supporting documentation.

Name: _____
Address: _____
_____
_____
_____
_____
Telephone Number: (___) _____

Signature of personal representative: _____

Date: _____

Notice: Without signature or proof of proper authority, this Authorization may be denied.

Please return completed and signed form to:

Attention: Harley Koehler
Kimberly-Clark Corporation
2001 Marathon Avenue
Neenah, WI 54956

Or by e-mail:
harley.koehler@kcc.com

WAIVER AND PERMISSION TO RELEASE
PERSONALLY IDENTIFIABLE INFORMATION

I, _____, understand that Kimberly-Clark Corporation or a subsidiary or related company of Kimberly-Clark Corporation (collectively, "Kimberly-Clark") has been served with a subpoena for certain records (the "Subpoena"), and such certain records may contain my personally identifiable information ("PII"), which Kimberly-Clark has acquired in connection with my current and/or former employment by Kimberly-Clark and/or third-party contractor relationship with Kimberly-Clark.

I hereby waive any right to inspect or review such records containing my PII, and I hereby give permission to Kimberly-Clark to release such records containing my PII to the party who served the Subpoena upon Kimberly-Clark.

By signing this document, I understand that I am waiving any right I may have to assert any claim for damage or harm, monetary or otherwise, that may arise, directly or indirectly, from Kimberly-Clark releasing such records containing my PII pursuant to the Subpoena.

Dated this _____ day of _____, 20___.

_____
Signature

_____
Print Name