USF UNIVERSITY OF SOUTH FLORIDA

Division of Human Resources

Benefit Information Authorization Release Form

PLEASE PRINT

Name: _____ Employee ID: _____

By signing this form I authorize the University of South Florida Division of Human Resources to release my benefit information to the following person(s) or organization(s):

Name of person(s) or organization(s)* _____

Street Address: _____

City, State and Zip Code: _____

Telephone Number(s): _____ Fax Number: _____

Purpose: _____

_____

_____

***For additional organizations or persons, please complete separate forms.**

I specifically authorize the release of the following benefit(s):

☐ All Benefit Information
☐ Leave Information
☐ Long-Term Disability
☐ Health Insurance
☐ Flexible Spending Account
☐ Short-Term Disability
☐ Dental Insurance
☐ Life Insurance (excluding beneficiaries)
☐ Vision Insurance
☐ Retirement (excluding beneficiaries)
☐ Other_____

I understand that I may revoke this authorization form at any time by notifying the Division of Human Resources at the University of South Florida. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have an effect on any information already released by the University of South Florida before the University received my written notice of revocation.

This authorization form expires on _____ or when _____ occurs.

- I may inspect and receive a copy of the information to be released pursuant to this Authorization form upon request.
- I understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.
- I also understand that I may refuse to sign this form.

_____ _____

Signature of Employee Date