



GARDEN GROVE UNIFIED SCHOOL DISTRICT

10331 Stanford Avenue • Garden Grove, CA 92840-6353
Phone: (714) 663-6000 • Fax: (714) 663-6100

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Permission to Release Protected Health Benefits Information

Employee Name: _____ Emp. ID #: _____ Phone#: _____

I give GGUSD Insurance Department permission to speak to the following person(s) regarding any medical, dental, vision and/or life insurance information.

Name _____ Relationship _____

Name _____ Relationship _____

I am aware if I no longer wish to allow this individual authorization to my health benefits information, I MUST submit a written letter to GGUSD Insurance Department to deny them any further access.

Signature

Date



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