AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Pursuant to the Privacy Act of 1974, 5 U.S.C. 552a, 29 CFR 1910.1020, and 42 CFR Part 2

1. Medical Care Provider Information

Clinic, Facility or Group Name:

____

Medical Care Provider(s) Name (Print or Type):

____

Address: ______________________________

____

____

2. Medical Care Provider Contact Information

Fax: ______________________________

Attention (check all that apply):

☐ Treating Medical Care Provider

☐ Other: ______________________________

☐ Other: ______________________________

Phone (include extension, if applicable): ______________

You are hereby authorized to furnish information <u>from</u> the record of the individual named below which is in the record system of your facility, and release it <u>to</u>: Department of Health & Human Services (DHHS), National Institutes of Health

MEP Medical Director or Designate Federal Occupational Health Medical Employability Program	AND	NIH Leave Bank Office or Designate National Institutes of Health Office of Human Resources

3. Name of Employee (Print or Type)

____

4. Specify extent and nature of information to be disclosed:

____

5. Purpose or need for the disclosure (check all that apply):

☐ Family and Medical Leave Act (FMLA)

☐ Voluntary Leave Bank Program (LB)

☐ Voluntary Leave Transfer Program (VLTP)

☐ Workers' Compensation (WC)

☐ Other: ______________

6. Specify the <u>projected</u> start date, end date and duration for the medical condition:

Start Date: ______ End Date: ______

☐ Continuous

☐ Intermittent ______ hours per ______

If FMLA was selected under Item 5, you must attach a memo that indicates the dates in which you would like to use under FMLA.

The DHHS is requesting medical information to support the employee's request for paid or unpaid leave under the FMLA, LB, VLTP, WC, and/or other personnel benefits. The employee's treating medical provider will not condition treatment, enrollment, or eligibility for benefits on whether or not the employee signs this authorization. The information disclosed is being sent to an entity that is not covered by the HIPAA Privacy Rule, and it will no longer be protected under HIPPA. However, this information shall remain confidential and is covered under DHHS policies and the Privacy Act. Information will only be furnished for the purposes related to the programs specified under Item 5. During the medical validation process, the medical consultant will review the employee's medical documentation and make a recommendation regarding how much leave is medically supported. The recommendation may or may not be consistent with the timeframe and duration indicated under Item 6.

7. Patient Information

Name: ______________________________

Date of Birth: ______________________________

SSN (last 4 digits only): ______________________________

Kaiser-Permanente Number (if applicable): __________

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8. Authorization

Signature of Applicant: ______________________________

Date of Signature: ______________________________

*This authorization for disclosure will be valid **6 months from the date of signature**, indicated above.*

If other than patient, state relationship: ______________________

Attach legal documentation, if applicable.

This authorization is subject to revocation at any time except to the extent that DHHS has already taken action. If this authorization has not been revoked; it will expired in accordance with the terms of the duration statement provided above. Revoking authorization may impact the employee's benefit status.

Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor and fined not more than $ 5,000 (5 U.S.C 552a(i)(3)); in the case of alcohol and drug abuse patient records, a falsified authorization for disclosure is prohibited under 42 CFR 2.31 and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5,000 for a subsequent offense, in accordance with 42 CFR 2.4.