HIPAA Compliant Authorization for Release of Medical Information

Family & Medical Leave Act — Commonwealth of Pennsylvania

1. Employee Information:

Employee Name	Personnel Number

2. Patient Information:

Patient Name	Date of Birth	Case / Record / Other ID Number (identify type of ID number)

3. Patient Certification and Authorization:

By my signature and attestation in Part 6, below, I authorize the Health Care Provider named in Part 4, below to disclose the Protected Health Information (PHI) from the records of the patient named in Part 2, above, as follows. Information to be used or disclosed includes only information related to the FMLA leave request provided by the Health Care Provider on the *Serious Health Condition Certification* form, as follows:

With respect to the information described above, where it includes the following special categories of PHI, I further indicate as follows by checking the appropriate box:

A. I authorize disclosure of necessary drug and alcohol information to the individual identified in Part 5, below. ☐ Yes ☐ No

B. I authorize disclosure of necessary mental health information to the individual identified in Part 5, below ☐ Yes ☐ No

C. I authorize disclosure of necessary HIV/AIDS information to the individual identified in Part 5, below ☐ Yes ☐ No

All information indicated is to be disclosed to the SPF Absence Coordinator identified in Part 5, below for the purpose of FMLA certification.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization, by writing to the below named Health Care Provider. Unless otherwise revoked, this authorization will expire six months from the date on which this authorization is signed.

The Health Care Provider is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand that the Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the individual identified in Part 5, below, and may no longer be protected by federal privacy regulations.

4. Health Care Provider:

Printed Name of Health Care Provider	Type of Practice/Medical Specialty

Address	Telephone Number
Name of Contact Person, if not the Health Care Provider	Fax Number

5. Person to Release Information To:

, SPF Absence Coordinator

Phone: Fax: E-mail:

6. Signature:

Attestation: I understand the nature of this authorization.

Signature of Patient or Personal Representative	Date

Print Name

If this authorization is signed by a personal representative of the above-named patient, the personal representative must describe his or her authority to act:	
Signature of Witness (if necessary, as per 55 PaCode 5100.34 (f) (6)-(7), relating to mental health facility records):	Date
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