**Family and Medical Leave Act**

**HIPAA Compliant Authorization for Release of Medical Information**

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| **Employee Information: TO BE COMPLETED BY EMPLOYEE OR PATIENT** |
| Employee Name | Personnel Number |
|  |  |
| **Patient Information: TO BE COMPLETED BY EMPLOYEE OR PATIENT** |
| Patient Name | Date of Birth | Case/Record/Other ID Number and Identify Type |
|  |  |  |
| **Patient Certification and Authorization: TO BE COMPLETED BY EMPLOYEE, PATIENT, OR PROVIDER** |
| By my signature and attestation in Part 6, below, I authorize the health care provider named below to disclose the Protected Health Information (PHI) from the records of the patient named 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  form, as follows:**NOTE: All corrections/additions to the *Serious Health Condition Certification* form must be initialed and dated by the Health Care Provider, and the form must be re-signed and re-dated by the health care provider. If corrections/additions are made on this form, the Health Care Provider must sign and date this form.**By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.**Signature of Health Care Provider Date**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:1. I authorize disclosure of necessary drug and alcohol information to the individual identified in the Person to Release Information to below. [ ]  Yes [ ]  No
2. I authorize disclosure of necessary mental health information to the individual identified in the Person to Release Information to below. [ ]  Yes [ ]  No
3. I authorize disclosure of necessary HIV/AIDS information to the individual identified in the Person to Release Information to below. [ ]  Yes [ ]  No

All information indicated is to be disclosed to the FMLA/SPF Coordinator identified in the Person to Release Information to 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 the Person to Release Information to below, and may no longer be protected by federal privacy regulations. |
| **Health Care Provider: TO BE COMPLETED BY EMPLOYEE OR PATIENT** |
| 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 |
|  |  |
| **Person to Release Information To:** |
|      ,FMLA/SPF Coordinator, Address:      , Phone:      , Fax:      , E-mail:       |
| **Signature of Patient or Personal Representative** |
| **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 \* | Date |
|  |  |
| Signature of Witness \* | Date |
|  |  |

\* Witness only needs to sign if records relate to Pa. Code 5100.34 (f) (6)-(7).