

**FMLA LEAVE REQUEST:
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM TREATING HEALTH CARE PROVIDER**



A health care provider may not use or disclose your protected health information (“PHI”) without a valid authorization unless otherwise permitted under law. To authorize the disclosure of your PHI, please complete and sign the form below and present it to your Health Care Provider, along with the applicable FMLA Certification form, which is available from your Agency HR Representative.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 DISCLOSURE

This authorization does not cover, and the information to be disclosed must not contain, genetic information. “Genetic information” includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving reproductive services.

Part 1. PATIENT’S INFORMATION

Name:		Employee ID (if applicable):	
Home Street Address:		Date of Birth:	
City:	State:	ZIP Code:	Phone Number:

Part 2. HEALTH CARE PROVIDER’S INFORMATION

Name:			
Address:			
City:	State:	ZIP Code:	Phone Number:

Part 3. RECIPIENT’S INFORMATION (AGENCY HUMAN RESOURCES)

.Agency: Pender County Human Resources Department		Attn: Brittany Kelly	
Street Address: 801 S. Walker Street		Fax Number: 910-259-1457	
City: Burgaw	State: NC	ZIP Code: 28425	Phone Number: 910-259-0224

Part 4. INFORMATION ABOUT THE USE OR DISCLOSURE

I, the undersigned individual, or a family member, have requested leave under the Family and Medical Leave Act ("FMLA"), relating to my medical, physical, behavioral and/or mental condition. To facilitate that request, I hereby authorize the Health Care Provider listed in Part 2 to release information about my health condition and treatment thereof as it relates to the current need for FMLA leave, with the limitations described immediately below.

The specific health information that I am authorizing to be released is limited to the information requested in the applicable FMLA Certification form, and is limited to only information relating to the serious health condition for which the current need for FMLA leave exists. Following receipt of a complete and sufficient certification, Human Resources at the Agency identified in Part 3 may contact the Health Care Provider directly if necessary to clarify and/or authenticate the certification.

The purpose for disclosure is to determine whether I qualify for leave under the FMLA, or whether my family member qualifies for leave under the FMLA to care for me.

The information is to be released to Human Resources at the Agency listed in Part 3.

This authorization is valid for one year from the date indicated below or upon receipt by the Health Care Provider of my signed, written notice to revoke my consent.

Part 5. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

I may revoke this authorization at any time before the expiration date by providing written notice to the Health Care Provider listed in Part 2. The revocation of my authorization must be in writing, it is not effective until the Health Care Provider receives it, and it will NOT affect any actions taken in reliance on my authorization before my written revocation notice is received.

I may see and copy the information described on this form if I ask for it.

I understand that signing this form is voluntary. The Health Care Provider may not condition treatment, payment, enrollment, or eligibility for health benefits on whether I sign this authorization.

I understand that I may refuse to sign this authorization form. However, I understand that if I refuse to sign this authorization form, it is the responsibility of the employee requesting FMLA leave to provide Human Resources with a complete and sufficient certification form in a timely manner and to clarify the certification if necessary. I understand that if the employee requesting leave refuses to provide a complete and sufficient certification form in a timely manner, this may result in the denial of FMLA leave. I also understand that if I choose not to provide an authorization allowing Human Resources to clarify the certification with the health care provider, and the employee requesting leave does not otherwise clarify the certification, this may result in the denial of FMLA leave if the certification is unclear.

The information that is used or disclosed pursuant to this authorization may be re-disclosed by the recipient as allowed under state or federal law.

Part 6. SIGNATURE OF PATIENT OR REPRESENTATIVE

I authorize the Health Care Provider to use or disclose my protected health information as described in Part 4.

Signature of patient or representative:	Date:
Printed name of patient's representative, if applicable:	Representative's relationship to patient: