Federal Occupational Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN – PRINT LEGIBLY AND USE BLACK OR BLUE INK

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.

II. THIS INFORMATION IS TO BE DISCLOSED BY:	**PROVIDED TO:** ***(Agency, Medical Provider, Individual)***
Name: Treating Provider Information ***Address:*** Phone: Fax: *Email Address:*	*Name:* FOH MEP Case Review Team ***Address:*** 5600 Fishers Lane Rockville, MD 20857 Phone: Fax: 301-827-9003 *Email Address:* medical.employability@foh.hhs.gov

III. THE PURPOSE OR NEED FOR DISCLOSURE IS (*check the applicable box*):

☐ Medical Services ☐ Personal Use ☐ Attorney ☐ Disability/Reasonable Accommodation ☐ Leave Bank/FMLA
☐ Other (specify) _____

IV. THE INFORMATION IS TO BE DISCLOSED FROM MY HEALTH RECORD (*check appropriate box(es)*):

☐ Work-related clearance, problems, or restrictions
(*If Sensitive Health Information is required, the client **MUST** select the applicable box in Sensitive Health Section V).*

☐ Only the period of events from _____ to _____
☐ Only information related to _____
☐ Other (*specify*) _____
☐ Entire Record

V. SENSITIVE HEALTH INFORMATION: CHECK THE APPLICABLE BOX(ES) BELOW IF ANY OF THESE ARE TO BE DISCLOSED.

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Sexually Transmitted Diseases
☐ HIV Status/AIDS and related treatment ☐ Mental Health *(other than psychotherapy notes)*

VI. DISCLOSURE AUTHORIZATION: SIGNATURE, DATE, AND VERIFCATION: *(Authorization is incomplete without signature and date).*

I understand that I may revoke this authorization by submitting a revocation notice in writing at any time to Federal Occupational Health, except to the extent that action has been taken in reliance on this authorization. If this authorization is requested as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim. If this authorization has not been revoked, it will terminate **six months** from the date of my signature unless a different expiration date is specified below.

(*Specify New Date*) _____.

I understand that FOH will not condition treatment or eligibility for care on my providing this authorization except if such care is provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

SIGNATURE OF CLIENT OR PERSONAL REPRESENTATIVE (*state relationship to client*)	**DATE**
SIGNATURE OF WITNESS (*if required*)	**DATE**

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. 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 (5 USC 552a (i)(3)).

Client Identification #/Verification Type :	Request Processed By:
Client Name (Last, First, MI):	Date Completed (MM/DD/YYYY):
Date of Birth (MM/DD/YYYY):	How was information provided : ☐ USPS ☐ UPS ☐ Fax ☐ In-Person ☐ E-mail
Client Address:	Attach Recipient confirmation (*USPS return receipt/fax confirmation*):

INSTRUCTIONS FOR COMPLETING FOH-AUD FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Federal Occupational Health (FOH) employee health record data are protected by The Privacy Act of 1974 (5 U.S.C. §522a), Genetic Information Nondiscrimination Act of 2008, 42 CFR Part 2, and subject to regulations within 5 CFR §§ 293 and 297, CFR 1910.1020, 44 U.S.C. §§3541-49, 29 U.S.C. §§657 and NARA GRS-1.

1. **Section I**, print your name to voluntarily release your medical information.

2. **Section II**, print the name, address, and phone number of the person/organization/facility releasing the information; if the releasing organization is not FOH, please provide a fax number and email address. Also, provide the name, address, phone, fax, email of the person/organization/facility that will receive the information.

    a. **NOTE:** Federal regulations protect the privacy of minors. Parents and legal guardians may not be given direct access to a minor's records by Federal Occupational Health's Employee Assistance Program (EAP). Therefore, EAP records requested by parents and legal guardians are sent directly to the designated health professional indicated in Section II of this form.

3. **Section III**, state the reason for information disclosure. If the reason is not listed, please choose 'other' and write the reason on the line provided.

4. **Section IV**, check the appropriate box as applicable.

    a. **Work-related clearance, problems, or restrictions** if sensitive health information is requested, such as HIV status, Behavioral Health and/or Substance Abuse, must select the applicable box in Section V.

    b. **Only the period of events from** – specify date range, e.g., Jan 1, 2013 to Feb 1, 2013.

    c. **Only information related to-** specify injury, treatments, etc**.**

    d. **Other (*specify*)** – e.g., testing result (by test name and date) and corresponding consultation, etc.

    e. **Entire Record** – complete record – only if specifically authorized by you will disclosure include the **sensitive health information** (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS status and/or treatment, and mental health status and/or treatment) indicated in this section

5. **Section V**, **IN ORDER TO RELEASE SENSITIVE HEALTH INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT/REFERRAL OR STATUS, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH STATUS OR TREATMENT/REFERRAL, THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE CLIENT IN SECTION V**

6. **Section VI,** if a different disclosure authorization expiration date is desired, specify a new date. Otherwise, this disclosure authorization request will expire **six months** from the date of signature.

    a. **PLEASE SIGN AND DATE** – authorization is incomplete without signature AND date. If making an in-person request, you will need to produce a Government or State issued photo identification (e.g., Driver's license or U.S. passport) for identity verification.

    b. If authorization is for a client, verify identification using the employee's federal ID and document the federal PIV card number on the authorization form.