MINNESOTA

Authorization For Release of Medical Information from Treating Health Care Provider

Use this form in connection with a request for leave under the Family Medical Leave Act ("FMLA") and/or the Minnesota Paid Leave ("MPL") law.

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 or MPL 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): _____

Date of Birth (mm/dd/yyyy): _____ Phone Number: _____

Home Street Address: _____

City: _____ State: _____ ZIP Code: _____

Part 2. Health Care Provider's Information

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Part 3. Recipient's Information (Agency Human Resources)

Agency: _____ Attn: _____

Phone Number: _____ Fax Number: _____

Street Address: _____

City: _____ State: _____ ZIP Code : _____

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") or Minnesota Paid Leave law, 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 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 or MPL certification form and is limited to only information relating to the serious health condition for which the current need for leave exists.

The purpose for disclosure is to determine whether I or my qualifying family member qualifies for leave under FMLA, Minnesota Paid Leave or both. The information is to be released to human resources at the agency listed in Part 3. 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.

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 my responsibility as the employee requesting leave under the FMLA or Minnesota Paid Leave law 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 I refuse to provide a

complete and sufficient certification form in a timely manner, this may result in the denial of leave under the FMLA or Minnesota Paid Leave law. I also understand that if I choose not to sign this authorization allowing human resources to clarify the certification with the health care provider, and I do not otherwise clarify the certification, this may result in the denial of leave under the FMLA or Minnesota Paid Leave law.

- 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 (mm/dd/yyyy): _____

Printed name of patient's representative, if applicable: _____

Representative's relationship to patient: _____