DEPARTMENT OF HEALTH & HUMAN SERVICES

Federal Occupational Health Service
Medical Employability Program
FAX: **301-594-3321**
Email: Medical.Employability@foh.hhs.gov

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

(Pursuant To The Privacy Act of 1974, 5 U.S.C. 552a, 29 CFR 1910.1020, and 42 CFR Part 2)

(The release of information about a patient who is treated or referred for treatment for alcohol or drug abuse, or the medical results of such abuse, is governed by the Confidentiality of Alcohol and Drug Abuse Patient Record Regulations, 42 CFR Part 2).

TO: ☐ **Treating Medical Care Provider**

(name) _____ (phone) _____

(address) _____ (fax) _____

(City) _____ (State) _____ (ZIP) _____

You are hereby authorized to furnish information from the record of the individual named below which is in the record system of your facility, and release it t

MEP Medical Director or Designate
Federal Occupational Health
Medical Employability Program

1. **Name of EMPLOYEE** (print or type)

2. Agency

Department of Health & Human Services - Health Resources & Services Administration - Loan Program (HHS HRSA LP)

3. Purpose or need for the disclosure (please check)

- ☐ COMPENSATION CLAIM(S)
- ☐ LEGAL
- ☐ REASONABLE ACCOMMODATION
- ☐ SICK LEAVE, FAMILY MEDICAL LEAVE
- ☐ OTHER _____

4. Specify extent and nature of information to be disclosed for each purpose or need indicated, and SPECIFY inclusive dates:

from _____ to _____

The Federal Occupational Health is requesting medical information supporting the employee's request for sick leave, Family Medical Leave (FMLA), accommodation under the Rehabilitation Act, or other personnel benefits. Information discussed is to be confidential. In cases where the individual may require first aid/emergency treatment, or if government officials are investigating compliance with the ADAAA, relevant information may be shared, as required by law.

This authorization is subject to revocation at any time except to the extent that DFOH or the other program specified which is to make the disclosure has already taken action in reliance on it. If this authorization has not been revoked otherwise, it will expire upon the termination of the interagency agreement that authorized the services provided by Federal Occupational Health for the subject individual's federal employer.

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 and fined not more than $ 5,000 (5 U.S.C 552a(i)(3)); in the case of alcohol and drug abuse patient records, a falsified authorization for disclosure is prohibited under 42 CFR 2.31 and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5,000 for a subsequent offense, in accordance with 42 CFR 2.4.

5. Print **Name of PATIENT**:

6. If other than subject, indicate relationship or authority: _____

7. Date of signature:

8. **Date of Birth:** _____

9. **Last four of SSN:** _____

10. Kaiser-Permanente Number (if applicable): _____

11. Signature of **PATIENT:**

12. Signature of Parent/Guardian/Power of Attorney.

The Medical Employability Program will only utilize a signed "Authorization for Release of Information" for a period of six (6) Months from the date of signature.