STATE EMPLOYEES' LEAVE BANK PROGRAM

AUTHORIZATION FORM FOR REVIEW OF RELEASED RECORDS AND INFORMATION

	Employ	yee's Name:	Date of Birth:
В.	<u>Directions for Release</u> : I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the individual listed in Section A to the individual(s) identified in Section B.1a.		
	B.1a.	 I authorize the disclosure of information to: State Medical Director State Employees' Leave Bank Program 	
	B.1b.	I authorize the release of information from: o (Specify Health Care Provider) o State Medical Director	
	B.2.	Information to be released: I authorize the disclosure medical records relating to the condition(s) for which I a	
B.3. Purposes: I authorize the disclosure and/or use for the following (a) to determine my eligibility for leave from the State Employee			
	B.4.	I am asking that you NOT provide any genetic information information. Genetic information, as defined by the Generic includes an individual's family medical history, the result tests, the fact that an individual or an individual's family and genetic information of a fetus carried by an individual embryo lawfully held by an individual or family member	netic Information Nondiscrimination Act of 2008, ts of an individual's or family member's genetic member sought or received genetic services, all or an individual's family member or an
C.	<u>Right to Revoke</u> : I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing: Jennifer Hine, Director, Personnel Services, Department of Budget and Management, 301 W. Preston Street, Room 705, Baltimore, MD 21201 or via Fax at 410-333-5440		
D.	<u>Authorization and Signature</u> : I authorize the review of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, the information to be disclosed is protected by law and the disclosure will conform with my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.		
	I have read the contents of this authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the review and/or disclosure of my confidential protected health information.		
		Employee Signature	 Date