STATE EMPLOYEES' LEAVE BANK PROGRAM

Authorization Form for Release of Records and Information

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee's Name: _____ Date of Birth: _____

B. Directions for Release:
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 Employees' Leave Bank Program
State Medical Director

B.1b. I authorize the obtaining of information from:
(Specify Health Care Provider) _____
State Medical Director

B.2. Information to be released: I authorize the disclosure and/or use of any information from my medical records relating to the condition(s) for which I am seeking leave.

B.3. Purposes: I authorize the disclosure and/or use for the following reason(s):
(a) for employment purposes
(b) to determine my eligibility for participation in the State Employees' Leave Bank Program

B.4. I am asking that you NOT provide any genetic information when responding to this request for medical information. Genetic information, as defined by the Genetic Information Nondiscrimination Act of 2008, 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 assistive reproductive services.

C. Right to Revoke: 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: Margaret Embardino, Director, Employee Medical Services Unit, Department of Budget and Management, 301 W. Preston Street, Room 508, Baltimore, MD 21201 or via Fax at 410-333-5440.

D. Authorization and Signature: I authorize the release 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 use and/or disclosure of my confidential protected health information.

_____	_____	_____
Your Signature	Signature of Witness	Date

(Revised February 2013)