

STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

AUTHORIZATION FORM TO REVIEW RECORDS AND INFORMATION

- A. **Identification:** This document authorizes the use and/or disclosure of confidential protected health information about the following person; **this document is not used to request additional medical records or information on the patient's behalf.**

Employee's Name: _____ Date of Birth: _____

Patient's Name (if not the employee): _____ 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:**

- My Appointing Authority or Designee
- State of Maryland Employee-To-Employee Leave Donation Program

B.1b. **I authorize the release 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) to determine my eligibility for leave from the State of Maryland Employee-To-Employee Leave Donation 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:** This authorization is required for every request for leave. 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. To revoke the authorization, I must contact, in writing: Yvette Romero, Deputy Director, Personnel Services, Department of Budget and Management at Yvette.romero@maryland.gov.

- D. **Authorization and Signature:** 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 understand that electronic signatures are not accepted on this form. 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

Patient Signature (if not employee)

Date