STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

REQUEST TO APPEAL FORM - FOR DENIAL OF LEAVE

(ALL FIELDS ARE REQUIRED)

NAME: _____ **DATE:** _____

HOME ADDRESS: _____

PERSONAL EMAIL: _____ **W#:** _____

JOB TITLE AND SUMMARY OF DUTIES:

_____

AGENCY NAME: _____ **LAST DAY WORKED:** _____

REQUEST IS FOR: EMPLOYEE ☐ **; OR,**

FAMILY MEMBER ☐ **FAMILY MEMBER NAME**: _____

My request for Employee-to-Employee leave should be reconsidered because:

In addition to submitting your appeal, please have your treating physician(s) fax or email any additional medical records that support your Employee-to-Employee Leave Appeal. The medical documentation should address only the period of time you are appealing. It must include detailed information that explains the severity and duration of your (or your family member's) medical condition(s). Please refer to the State Employee-to-Employee Leave Donation Program – Medical Documentation sheet you received with your denial letter for examples of the types of documentation that should be provided.

The appeal and the records may be emailed or faxed. Please follow the instructions in your denial letter.

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AUTHORIZATION FORM FOR REVIEW OF RELEASED 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:
- o My Appointing Authority or Designee
- o State of Maryland Employee-To-Employee Leave Donation 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 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: 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. 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 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 for determining my eligibility for leave.*

_____	_____	_____
Employee Signature	Patient Signature (if not employee)	Date

(Rev. 4/2018)

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MEDICAL DOCUMENTATION*

In most situations, your leave request will be evaluated without benefit of a personal examination. Please have your health care provider(s) submit appropriate medical documentation to support your request. The best thing to submit for a favorable consideration is medical documentation that **addresses ONLY the period of time for which the leave is requested.**

Listed below are examples of the type of medical documentation that should be submitted, if applicable:

1)	Office Visit Notes
2)	Hospital Records (Operative Report & Discharge Summary)
3)	Physical & Diagnostic Findings
4)	Physician's Statement Of Current Disability, Symptoms And Physical Limitations (to explain why you cannot perform your job duties) and Prognosis
5)	Laboratory Reports (EEG, Myelogram, Angiography, Cat Scan, Etc.)
6)	Reports Of X-Rays As Read By Examining Physician
7)	Physical Therapy Notes
8)	Reports from Specialists
9)	Date **and** proof of surgery or other Procedure
10)	For Pregnancy Cases, Expected Due Date **and Actual Delivery Date, Type of Delivery** and Copy of Antepartum Record; a birth certificate is not medical proof for birth.

*You must also provide sufficient medical documents to allow your request to be reviewed appropriately if your request is to care for a family member.

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