

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION RE: FAMILY MEDICAL LEAVE ACT (FMLA) REQUEST

For this authorization, "My Health Information" includes any supplemental health information pertaining to my request under the Family Medical Leave Act.

I authorize \_\_\_\_\_ to disclose My Health Information to the Johns Hopkins \_\_\_\_\_  
(name of physician/health care provider)  
\_\_\_\_\_ and to the Johns Hopkins \_\_\_\_\_  
(name of JH entity and appropriate benefits or HR office) (name of JH entity and appropriate employee health office)  
to determine my eligibility for benefits under the Family Medical Leave Act (FMLA).

This authorization is valid for one year from date signed, unless I revoke this authorization. Johns Hopkins may contact me to extend this authorization, but I do not have to do so.

I recognize that there is the potential for My Health Information disclosed under this authorization to be subject to redisclosure and therefore no longer to be subject to the protection of confidentiality rules applicable to my health care provider.

I am not required to sign this authorization. Johns Hopkins does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. However, if I do not sign this form I understand that my FMLA request may not be able to be processed. I will receive a copy of this authorization upon signature.

I may revoke this authorization at any time in writing by following the guidelines on the back of this form.

**Employee's Name:**

\_\_\_\_\_  
(first) (m. initial) (last)

**Signature:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:**

\_\_\_\_\_  
(street address)

\_\_\_\_\_  
(city) (state) (zip code)

**Phone:**

\_\_\_\_\_  
(area code) (home phone number)

**SSN:**

\_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.**

**Notice to any recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part 2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.**

I may revoke this authorization by mailing or delivering my written request along with a copy of the original authorization to:

The physician/health care provider that provided My Health Information, with a copy to:

My employer's benefits or human resources office where my authorization was made.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information.

- Date of the authorization,
- Name,
- Address,
- Phone number,
- Medical record number,
- Social security number,
- Date of birth,
- Purpose of authorization,
- A description of the health information covered by the authorization,
- The person or entity authorized to use the data.

Forms added 6/03

<http://www.dol.gov/esa/regs/compliance/whd/fmla/wh380.pdf>

<http://www.dol.gov/esa/forms/whd/WH-381.pdf>