

ATTACHMENT 2

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(Sample -- Family and Medical Leave)**

I, _____, hereby authorize the use or disclosure of
Name of Employee
my health information as described in this authorization.

(1) Specific person or organization authorized to provide the information:

(2) Specific person or organization authorized to receive and use the information:

(3) Specific and meaningful description of the requested information:

<For example, medical examination report and conclusions related to a fitness-for-work examination.>

(4) Purpose of the request:

<State the purpose of the request or use: "At the request of the individual".>

(5) Right to revoke authorization: I understand that I have the right to revoke this authorization at any time by notifying *<Department Name>* in writing at *<Include the address where revocation must be delivered>*. I understand that the revocation is only effective after it is received and logged by *<Department Name>*. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose this information.

(7) I understand that my Family and Medical Leave may be conditioned on my agreement to this authorization and any additional authorization *<Department Name>* requests.

(8) I understand that I am entitled to receive a copy of this authorization.

(9) I understand that this authorization will expire when my employment with *<Department Name>* terminates.

Employee's Signature _____ Date _____
or Personal Representative

Personal Representative Section

If a personal representative executes this form, that representative certifies that he/she has authority to sign this form on the basis of _____