Employee Authorization for Disclosure of Protected Health Information To Employer

Federal regulations, called the HIPAA Privacy Rule, provide important protections for your health information. The Privacy Rules apply to the use and disclosure of this protected health information by health care providers, health plans and health care clearinghouses. These covered entities may not require you to provide an authorization for treatment, payment or health care. However, they must obtain your authorization for disclosure and use for other purposes.

In order that we may obtain health information about you from your health care provider for the specific purpose of any necessary authentication and/ or clarification of the Family and Medical Leave (FML) Certification of a Health Care Provider you provided to substantiate your request for FML, you will need to complete, sign and date this authorization form.

I, ____ hereby authorize:
(*print name*)

Provider/Hospital/Clinic: Keller Family Chiropractic, LLC
Address: 10400 Lancaster-Newark Rd NE, Millersport, OH 43046

its Director or designees, or Medical Information Services Department to release any and all information regarding my treatment or condition contained in my entire patient record to the extent it relates to the FML Certification of a Health Care Provider. (This authorization does not extend to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. § 164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical record.) I specifically authorize you to disclose this information orally and in writing.

1. Person(s) or organization(s) to whom disclosure is to be made:

____ ____

____ ____

2. Specific type of information to be disclosed (if more limited than designated above):

Information for authentication or clarification of responses to the FML Certification of a Health Care Provider. *Authentication* means providing the health care provider with a copy of the certification and requesting verification that the information contained on the certification form was completed and/or authorized by the health care provider who signed the document. *Clarification* means contacting the health care provider to understand the handwriting on the medical certification or to understand the meaning of a response. Employers may not ask health care providers for additional information beyond that required by the certification form.

3. Purpose or need for disclosure:

Information from your health care provider may be needed to for authentication or clarification of responses to the FML Certification of a Health Care Provider in order to approve your request for FML.

4. This authorization expires: Date: ____________________________

This authorization is subject to written revocation at any time except to the extent that the health care provider has already taken action in reliance on the authorization. I understand that the information disclosed is subject to re-disclosure within the Keller Family Chiropractic, LLC and will no longer be protected by the federal Privacy Rules, 45 C.F.R. Parts 160 and 164. (HIPAA Authorization 45 C.F.R. 164.508)

Signature: ____________________________________ **Date:** _________________