Authorization for Disclosure of Information

Department of Health and Human Services, Federal Occupational Health (FOH) Services

FOH-6

The use of this form is voluntary. This form is used by FOH to obtain medical certification related to your Family Medical Leave Act (FMLA) and Reasonable Accommodation request from your health care provider. By providing the information requested on this form, FOH will be able to obtain information from your medical provider. FOH will use this medical information to develop a medical recommendation that will be provided to your IRS Point of Contact (POC). IRS has designated six (6) Labor Relations Assistants to handle FMLA requests and twenty-five (25) Reasonable Accommodation Coordinators to handle ergonomic and reasonable accommodation requests. Your IRS POC will forward the FOH recommendation to your manager who will then make the final determination on your request. FOH will only share the necessary medical information required for your manager or supervisor to make a decision on your request. All other medical documentation will be kept in your case file at FOH.

SECTION 1 Employee Information

Name of employee (*Last, First, Middle Initial*)				Gender ☐ Male ☐ Female
SEID number	Date of birth *(mm-dd-yyyy)*	City of IRS office	State of IRS office	Office ZIP code
IRS office telephone number *(include area code)*		Position title		Series and Grade

SECTION 2 Identify the Purpose or Need for the Disclosure *(Check only one box)*

☐ ERGO - Ergonomic Assessment ☐ RA - Reasonable Accommodation

☐ FMLA - Family Medical Leave Act ☐ Other _____

SECTION 3 Employee's Treating Health Care Provider Contact Information

Name of health care provider

Mailing address *(street address - no P.O. Boxes)*

City	State	Office ZIP code
Office telephone number *(include area code)*	Office FAX number *(include area code)*	

SECTION 4 Instructions for the Treating Health Care Provider

Your patient has requested leave under FMLA or RA. FOH Services seeks a response as to the frequency or duration of a condition, treatment, etc. Your response should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA or RA coverage. Limit your responses to the condition for which the employee is seeking leave.

You are hereby authorized to furnish information from the record of the patient named below, which is in the record system of your facility, and release it to: **Federal Occupational Health (FOH) Services**, Bethesda, MD FAX number 301-594-3321

Name of patient	Agency

I authorize the disclosure of my medical information, related to my FMLA or RA request made on _____ to FOH Services located in Bethesda, MD. I am allowing my doctor or primary health care provider to release medical information pertaining to my condition for which I am seeking FMLA or RA and only for medical records dated:

from to the expiration of this release.

SECTION 5 Employee Signature

Name of patient	Patient signature	Date signed

Signature of Parent/Guardian/Power of Attorney *(if patient lacks capacity to sign)*	Date signed	Relationship to patient

If insured by Kaiser Permanente, provide your Kaiser Permanente number	Patients date of birth *(mm-dd-yyyy)*

This authorization expires one year from the date the patient signed this form in Section 5.

This authorization is subject to revocation by the employee at any time except to the extent that FOH has already taken action in reliance on it. If this authorization has not been revoked in writing, it will expire with the terms of the duration statement provided above. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor and fined not more than $ 5,000 (5 U.S.C 552a(i)(3)); in the case of alcohol and drug abuse patient records, a falsified authorization for disclosure is prohibited under 42 CFR 2.31 and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5,000 for a subsequent offense, in accordance with 42 CFR 2.4. The release of information about a patient who is treated or referred for treatment for alcohol or drug abuse, or the medical results of such abuse, is governed by the Confidentiality of Alcohol and Drug Abuse Patient Record Regulations, 42 CFR Part 2.

Genetic Information and Nondiscrimination Act (GINA) A complete description of the GINA (Document 12986) is available for review.

Privacy Act Notice The Agency will retain a copy of Form 14258, Authorization for Disclosure of Information, and any accompanying documentation should an employee chose to provide the forms directly to their Manager or IRS POC. A complete Privacy Act Notice for Patients (Document 12987) is available for review.