EMPLOYEE / PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **Authorization:** I, _____(employee name), hereby authorize_____

_____

(name and address of healthcare provider) to disclose to the City of Henderson the following protected health information ("PHI"):

2. **Purpose Of The Disclosure:** I understand this information may be shared with certain employees of the City of Henderson who have a business need to know, in relation to: (1) assessing my continuing ability to perform the essential functions of my job or another open and available job for which I am qualified, with or without reasonable accommodation; (2) understanding the nature and extent of my medical impairments, and evaluating whether I may have a disability under state or federal law entitling me to reasonable accommodations or if I may require emergency assistance; (3) evaluating requests for leaves of absence or disability benefits; (4) evaluating workers' compensation injury claims; (5) evaluating claims, applications or requests for any other company benefits whether offered directly or through an insurance carrier or third-party provider; (6) investigating any potential violations of company policy, including but not limited to fraudulent requests for leave or benefits; (7) investigations or audits being conducted by a governmental agency or government official; and (8) any litigation against the City of Henderson or any of its related business entities, agents, employees, insurers or reinsurers whereby this information is relevant.

3. **Scope of The Disclosure:** I specifically authorize my health care provider to provide the City of Henderson with answers to the questions set forth in the Medical Certification Form. At your express request and authorization, the City may directly communicate with your health care provider.

4. **Revocation Rights**: I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to the health care provider identified in paragraph 1, above. I understand that the revocation will become effective upon receipt. I understand that any PHI disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation. However, I also understand that such revocation and refusal to provide requested medical information may affect my ability to return to work or continue working, or for accommodation requests to be granted, since this information is essential for the City of Henderson to properly evaluate my medical restrictions and accommodation options (if applicable). I further understand any request for a leave of absence or request for any company benefits may be delayed and/or denied if the City of

Henderson is unable to obtain health information necessary to properly assess such a request because I revoked this Authorization, or if I do not properly sign, date and deliver this authorization or any person subject to HIPAA that receives it does not provide the requested information.

5. **Further Disclosure:** I understand that once the health care provider identified in paragraph 1, above, discloses PHI pursuant to this Authorization, the PHI may no longer be protected under federal law, and the recipient may further disclose the PHI which it receives pursuant to this Authorization without my consent. Medical information obtained through this waiver will generally only be disclosed to employees with a business need to know, emergency personnel, and government officials or government agencies conducting investigations or audits.

6. **Expiration Date:** I understand that this Authorization will expire two (2) years from the date this authorization is executed by me.

7. I understand that the health care provider identified in paragraph 1, above, may condition treatment and/or the performance of examinations (medical examinations related to the interactive process, return to work or fitness for duty exams) which are solely for the benefit of my employer who is the recipient identified in paragraph 1, above, on my signing this Authorization.

8. I understand that a photographic copy of this Authorization is as valid as the original, and that I am entitled to receive a copy of this Authorization.

Signature of Employee: _____ Date:_____

(Print full Name)

_____

(Signature)

If completed by the employee's personal representative:[1]

Signature of Personal Representative: _____ Date:_____

(*Print full Name*)

_____

(Signature)

Description of Personal Representative's Authority or Relation to Employee (such as parent or legal guardian):

_____

[1] Personal Representative must provide a description of his/her authority to act on behalf of the individual.