

**FARM CREDIT FOUNDATIONS
AUTHORIZATION FOR THE RELEASE OF
PROTECTED HEALTH INFORMATION
BY HEALTH CARE PROVIDER TO EMPLOYER**

By signing this Authorization you, _____ (the "Patient"), agree to the release of your Protected Health Information¹ as outlined below. This Authorization is intended to comply with the authorization requirements of the HIPAA² Privacy Rule.³ When you have read through this Authorization, please ask Human Resources to explain anything you do not understand. If you agree with this Authorization, please sign and date it at the end of this form.

I. INFORMATION ABOUT THE RELEASE

1. My Authorization applies to the following Protected Health Information:

- Most recent physical examination report
- Drug test report
- Fitness for duty examination report
- Disability examination report
- Records relating to (specify injury or sickness) _____
- Health record from (insert dates) _____
- Confirmation that I am following recommendations
- Other (specify) _____

2. The reason for the release of my Protected Health Information is:

- Post-offer pre-employment physical
- Drug testing
- Fitness-for-duty determination
- Assistance with ADA reasonable accommodation
- Disability determination

¹ "Protected Health Information" is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly (*i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by the Health Care Provider.

² "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

³ The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

___ The employer is assisting me with a benefit claim under the employer's benefit plan

___ At my request

___ Other(specify) _____

3. The name and address of the Health Care Provider who or which has the information is:

_____.

Physicians, nurses, other health care providers, central records personnel and office staff are authorized to release the information.

4. The name and address of the Employer authorized to receive this information is:

This information should be directed to the Human Resources Department.

I understand that if my Protected Health Information is released to someone who is not required to comply with the HIPAA Privacy Rule, such information may be re-disclosed and would no longer be protected by the Privacy Rule.

5. This Authorization will expire on the following date or event:_____.

II. INFORMATION ABOUT YOUR RIGHTS

1. I understand that I have the right to refuse to sign this Authorization. If the Employer requires the information described above as a condition of my employment, however, I understand that my initial or continued employment and position are subject to my agreement to sign this Authorization.

2. I understand that I have the right to revoke my Authorization prior to the expiration date (in item #5) by notifying the Health Care Provider, in writing, but the revocation will not have any effect on actions taken in reliance on the Authorization.

III. SIGNATURE

By my signature, I certify that: (a) I have read this Authorization; (b) I have discussed any questions I have with Human Resources; (c) I agree to the release of my Protected Health Information as described in this Authorization; and (d) I will receive a signed copy of this Authorization.

Signature of Patient

Date: _____

OR _____
Signature of Personal Representative
(Verification of Authority Required)

Date: _____