Instructions: AUTHORIZATION FOR DISCLOSURE OF INFORMATION

The NIH 2923 must be signed by the patient, the patient's guardian, or someone holding the patient's Power Of Attorney (POA). POA's submitting the NIH 2923 on the behalf of the applicant must provide a copy of the original POA documentation.

Cases that would not require primary medical documentation attached (NIH 2923 only) with the NIH Leave Bank Recipient Package are:

- Appeals
- Psychological/Psychiatric conditions

Medical documentation should consist of copies of clinical office records, test results and/or hospital records. All documents should be current and include:

- A complete medical history, as it relates to the serious health condition,
- The findings of the physical exam and diagnostic testing,
- The treating physician's clinical impression,
- The treatment provided, and
- The patient's response to the treatment.

All cases in which the medical provider and patient are located outside of the US, the employee should submit primary medical documentation regardless of case and medical emergency type.

The DHHS is requesting medical information to support the employee's request for paid or unpaid leave under the FMLA, LB, VLTP, WC, and/or other personnel benefits. The employee's treating medical provider will not condition treatment, enrollment, or eligibility for benefits on whether or not the employee signs this authorization. The information disclosed is being sent to an entity that is not covered by the HIPAA Privacy Rule, and it will no longer be protected under HIPPA. However, this information shall remain confidential and is covered under DHHS policies and the Privacy Act. Information will only be furnished for the purposes related to the programs specified under Item 5. During the medical validation process, the medical consultant will review the employee's medical documentation and make a recommendation regarding how much leave is medically supported. The recommendation may or may not be consistent with the timeframe and duration indicated under Item 6.

This authorization is subject to revocation at any time except to the extent that DHHS has already taken action. If this authorization has not been revoked; it will expired in accordance with the terms of the duration statement provided above. Revoking authorization may impact the employee's benefit status.

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.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
Pursuant to the Privacy Act of 1974, 5 U.S.C. 552a, 29 CFR 1910.1020, and 42 CFR Part 2

Medical Care Provider Information
Clinic, Facility or Group Name:
_____

Medical Care Provider(s) Name (Print or Type): _____
_____

Address:_____
_____
_____

Medical Care Provider Contact Information
Fax: _____

Attention (check all that apply):
☐ Treating Medical Care Provider
☐ Other: _____
☐ Other: _____

Phone (include ext., if applicable): _____

You are hereby authorized to furnish information from the record of the individual named below which is in the record system of your facility, and release it to: Department of Health & Human Services (DHHS), National Institutes of Health

MEP Medical Director or Designate
Federal Occupational Health
Medical Employability Program

AND

NIH Leave Bank Office or Designate
National Institutes of Health
Office of Human Resources

Name of Employee (Print or Type) _____

Specify extent and nature of information to be disclosed:
_____
_____
_____

Purpose or need for the disclosure (check all that apply):
☐ Family and Medical Leave Act (FMLA)
☐ Voluntary Leave Bank Program (LB)
☐ Voluntary Leave Transfer Program (VLTP)
☐ Workers' Compensation (WC)
☐ Other:_____

Specify the projected start date, end date and duration for the medical condition:
Start Date: _____ End Date: _____
☐ Continuous
☐ Intermittent _____ hours per _____
If FMLA was selected under Item 5, you must attach a memo that indicates the dates in which you would like to use under FMLA.

Patient Information
Name: _____

Date of Birth: _____

SSN (last 4 digits only): _____

Kaiser-Permanente Number (if applicable): _____
_____

Authorization
Signature of Applicant: _____

Date of Signature: _____

*This authorization for disclosure will be valid **6 months from the date of signature**, indicated above.*

If other than patient, state relationship: _____
Attach legal documentation, if applicable.