City of San Rafael

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____ , hereby voluntarily authorize the disclosure of protected health information as described below:

The information is to be disclosed by:	**And is to be provided to the following recipient:**
Health Plan provider:	Name of person authorized to receive the disclosed Information: **City of San Rafael- Human Resources**
Address:	Address: **1400 Fifth Avenue, Room 210** **San Rafael, CA 94901**

My Protected Health Information (PHI) will be used/disclosed for the following purpose(s):

☐ Pre-employment Physical

☐ Federal Family Care & Medical Leave (FMLA), California Family Leave (CRFA), and/or California Pregnancy Disability Leave (PDL)

☐ A Reasonable Accommodation Request (ADA Accommodation)

☐ Other (please explain): _____

_____

_____

I understand that I have the right to revoke this authorization. I understand that my request to revoke this authorization must be in writing and can be mailed to:

City of San Rafael
Attn: Human Resources
1400 Fifth Avenue, Room 210
San Rafael, CA 94901

I understand that my protected health information may be subject to re-disclosure by the recipient and is no longer protected by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996.

Employee Name: _____
Address: _____
Signature: _____ Date: _____