Community College of Philadelphia

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

EMPLOYEE: Name:____ (Please Print) Social Security Number:____________________ Date of Birth:______________
PATIENT (if different): Name:____ (Please Print) Social Security Number:____________________ Date of Birth:______________

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members with certain exceptions including requests for family medical history to comply with the certification provisions of the FMLA or State or local family and medical leave laws, or pursuant to a policy (even in the absence of requirements of Federal, State, or local leave laws) that permits the use of leave to care for a sick family member and that requires all employees to provide information about the health condition of the family member to substantiate the need for leave. If this exception provision is not applicable in your case, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information', as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I hereby affirm that I am the above-mentioned employee of Community College of Philadelphia, or the legally authorized representative of the above-mentioned employee. I hereby authorize:

____

(Name of healthcare provider(s) or facility making disclosure)

To disclose to the appropriate representative in the Human Resources Department at Community College of Philadelphia, any and all medical information necessary to evaluate and determine my eligibility for benefits, for example: Family and Medical Leave, ADA, paid sick leave, unpaid medical leave of absence.

This authorization is valid from the date signed until:

________________________ (enter date) OR Indefinitely (check) _________

Limitations: ____

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(Signature of Employee) (Date)

(Signature of Authorized Representative) (Date)