



826 South 1500 East  
Naples, UT 84078  
(435) 781-3100

**AUTHORIZATION FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

***For consideration of Sick Leave Bank days, employee must also submit completed Uintah School District Sick Leave Bank Application Form and Certification of Health Care Provider Form***

**Introduction**

I hereby authorize the use and/or disclosure of my individually identifiable health information as described herein. I understand that this authorization is voluntary. Except for the below-stated protections accorded ALCOHOL AND DRUG ABUSE and records covered by The Genetic Information Nondiscrimination Act of 2008 (GINA), I also understand that the information released hereby may no longer be protected by federal privacy regulations if the organization authorized to receive said information is not a health plan or health care provider.

**Employee/Patient Name:** \_\_\_\_\_

**Employee/Patient DOB:** \_\_\_\_\_

Persons/organizations providing information:      Persons/organizations receiving information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specific Description of Information**

All pertinent information related to diagnoses of and treatments for \_\_\_\_\_  
\_\_\_\_\_ [physical/mental  
health conditions] from \_\_\_\_\_ [date] through \_\_\_\_\_ [date].

**Scope of Authorization**

I authorize and direct you to discuss my health information with and to permit the examination and copying of related documents if requested by [Agency/School District/Higher Education Institution]. You are also authorized to disclose related health information at my request from time to time without the need for another formal authorization.

**Alcohol/Drug Abuse Records**

I understand that, if relevant, this consent is sufficient to include disclosure of ALCOHOL AND DRUG ABUSE records, IF ANY, which are protected by the provisions of Federal Regulation 42 CFR Part 2. This consent is premised upon the requirement that all disclosures of alcohol and drug abuse records, if any, made pursuant to this authorization shall be accompanied by the following notice:

NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure

**Genetic Information Nondiscrimination Act (GINA)**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, 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.

**Purpose of Requested Use and Disclosure**

To assist me and my employer in the evaluation of my personal health conditions and their impact upon my ability to perform the essential functions of my job with or without a reasonable accommodation in accordance with the Americans with Disabilities Act.

**Expiration/Revocation/Option to Refuse**

The authorizing individual (or his/her authorized representative) must read and initial the following statements:

1. This authorization will expire on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. Initials:\_\_\_\_\_
2. I may revoke this authorization at any time by notifying the parties in writing. A written revocation will not affect on any actions taken prior to its receipt. Initials:\_\_\_\_\_
3. I understand that I may refuse to sign this authorization. Initials:\_\_\_\_\_
4. Photocopies of this signed authorization shall be treated as executed originals. Initials:\_\_\_\_\_

\_\_\_\_\_  
**Signature of Employee/Patient/Personal Representative**

\_\_\_\_\_  
**Date**

Printed Name:\_\_\_\_\_

Description of, or basis for, authority to act on behalf of authorizing individual (if applicable):  
\_\_\_\_\_