SALEM SCHOOL DISTRICT
Salem, Connecticut

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (FMLA)

I hereby Authorize the use and disclosure of my individually identifiable health information as described below:

- I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or payment or eligibility for benefits under a health plan.
- I understand my initial and continued employment and position, and/or leave of absence, are subject to my agreement to this Authorization and any additional authorization my employer requests.
- I understand that I am entitled to receive a copy of this form upon signing it.
- I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

Patient Name:	
ID Number:	
Person or organization authorized to RELEASE my health information:	Name: Address: City, State and Zip: Phone Number:
Person or organization authorized to RECEIVE my health information:	Name: Address: City, State and Zip: Phone Number:
Specific description of information is to be disclosed (be specific, include dates): The information requested in the attached Certification of Health Care Provider (Family and Medical Leave) form.	
What is the purpose of the disclosure? Medical certification of the need for medical leave from employment, including follow-up certifications during the leave and fitness for duty certification prior to return from leave.	
This Authorization will expire on (date or event):	
Signed:	Date
Patient Name (Print):	
If signed by a patient representative Representative Name (Print):	Relationship to patient, including authority for status as representative:

- ***Note: This form does NOT authorize the release of psychotherapy notes.***