University of Maine System
Authorization to Release Medical/Health Care and Personnel Information

Employee Name: _____

Employee Email: _____

Employee Birth Date: _____

Job Title: _____

Name of Health Care Provider: _____

Address of Health Care Provider: _____

I authorize my employer (acting through its Equal Opportunity Office) to obtain medical records and information, including records relating to my diagnosis, prognosis, functional limitations and restrictions, treatment plan, and recommended accommodations, from my health care provider (named above) **that relate to my request for accommodations** from the University. I understand that these records will be used only for the specific purposes of:

- determining whether I am qualified individual with a disability under the Maine Human Rights Act, the Americans with Disabilities Act, and/or the Rehabilitation Act of 1973;
- understanding the effect of my condition on my ability to do the essential functions of my job; and/or
- identifying potential accommodations that may help me stay at or return to work.

Note to Health Care Provider (GINA): *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information about employees or their family members. To comply with this law, please do not provide any genetic information in response to this request. "Genetic information" includes, among other things, an individual's family medical history, the results of genetic tests of an individual or an individual's family members, and the fact that an individual or an individual's family member has sought or received genetic services.*

I understand that my medical information will not be shared with my manager except for the purposes of identifying medical restrictions and limitations provided by my health care provider. My records will be maintained in a separate location from my personnel file and will remain confidential except as described above.

I understand that my specific permission is needed for disclosure of certain kinds of very sensitive information pertaining to the following. My specific permissions are noted as follows:

(A) **HIV status information** (select one)

☐ I **do** authorize disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS.

☐ I **do not** authorize disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS.

(B) **Substance Abuse Treatment Information** (select one)

☐ I **do** authorize disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse. Unless otherwise revoked, this **specific** authorization will expire on _____, 20____ or 6 months from the date of signing whichever comes first.

☐ I **do not** authorize disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse.

(C) **Mental Health Treatment Information** (select one)

☐ I **do** authorize disclosure of health information related to mental health treatment, not including Psychotherapy Notes.

☐ I **do not** authorize disclosure of health information related to mental health treatment, not including Psychotherapy Notes.

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to disclose all or some health information, but that refusal may limit the University's ability to provide a reasonable accommodation that I may need to do my job. I understand that the Health Insurance Portability and Accountability Act (HIPAA) may not apply if my information needs to be re-disclosed but that state and University privacy requirements are still in place. I understand that my health care provider will not condition the provision of my treatment on whether I sign this authorization.

I also authorize my employer to release to my health care provider any information and documents relevant to my request for accommodations, including but not limited to information about my job responsibilities, work environment, and job performance.

I have the right at any time to revoke this release and to refuse authorization to disclose all or some medical information. I understand that revocation may limit the University's ability to provide a reasonable accommodation that I may need to do my job. I can revoke this release by providing written notice to my campus Human Resources or Equal Opportunity office. My revocation does not apply to information already received. Unless I revoke this release, it will remain in effect for one year from this date. If I have questions about use or disclosure of my health information, I may contact my campus Human Resources or Equal Opportunity office. I am entitled to a copy of this release.

Employee Signature: _____

Date: _____

Notice to the University Regarding Its Receipt of Substance Abuse Treatment

Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Return this completed form to:

ADA Coordinator
Equal Opportunity Office
5713 Chadbourne Hall, Room 406
University of Maine
Orono, ME 04406

Fax: 207.581.1214
Email: equal.opportunity@maine.edu