



**TO BE COMPLETED BY THE EMPLOYEE**

**Employee's name** (first name, middle initial, last name)

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**Care recipient's (patient's) name** (first name, middle initial, last name)      **Care recipient's (patient's) date of birth** (MM/DD/YYYY)

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\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

I, , **authorize my health care provider listed on this form to**

**release my personal health information to**  **and their**

**employer's PFL insurance carrier** .

**Records Subject to Release:** This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

**Duration of Revocable Release:** This authorization ends after one year, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

HIV/AIDS related information     Mental health information     Alcohol/drug treatment     Psychotherapy notes

**Health Care Provider Information** (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

**1. Health care provider's name**

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**2. Health care provider's mailing address**

Mailing address

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City, State      Zip code      Country (if not U.S.A.)

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**3. Health care provider's telephone number** (provide area or country code)

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*Form PFL-3 continued on next page*



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**Care recipient's (patient's) name** (first name, middle initial, last name)

**Care recipient's (patient's) date of birth** (MM/DD/YYYY)

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**RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION** (to be completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

*Form PFL-3 continued from prior page*

**Care Recipient Information** (to be completed by the care recipient or authorized representative)

**4. Care recipient's mailing address**

Mailing address

City, State

Zip code

Country (if not U.S.A.)

**5. Care recipient's Social Security Number** □□□□ - □□ - □□□□

**6. Care recipient's telephone number** (provide area or country code)

**READ AND SIGN BELOW**

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the employee identified on the PFL-4 form. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

Care recipient's signature

Date signed (MM/DD/YYYY)

□□ / □□ / □□□□

**Authorized representative**

Print name

I, \_\_\_\_\_, represent the care recipient in this matter as authorized by:

Parental right    Power of attorney (attach copy)    Court order (attach copy)    Health care proxy (attach copy)

Authorized representative's signature

Date signed (MM/DD/YYYY)

□□ / □□ / □□□□

**The employee should retain a copy for their own records.**