CITY OF KLAMATH FALLS
AUTHORIZATION FORM FOR RELEASE OF RECORDS AND INFORMATION
RELATING TO AFSCME EMPLOYEE REQUEST FOR SICK LEAVE DONATION

COMPLETE SECTION A:

A. Identification
This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee Name: _____

What City Division do you work in? _____

Daytime contact phone number (in case questions arise): (_____) _____

B. Directions for Release
This authorization applies in accordance with my directions as indicated below. I authorize the City of Klamath Falls to release and/or use confidential, protected health information pertaining to the employee listed in Section A to the individual(s) and/or committee identified in Section B.1a for the purposes described herein. I understand that the information to be disclosed and/or used may include the completed Request for Sick Leave Donation form, any charts or summaries created by the City showing the use of my leave accruals, and any information I have provided in connection with my sick leave donation request (more fully described in §B.2 as "Application Information").

B.1a. I authorize the disclosure of Application Information to the Donation Committee and any person(s) interested in donating sick leave who request such Information.

B.1b. I authorize the obtaining of Application Information from: City Human Resources ; the Donation Committee; and my legal representative (name if applicable): _____
_____

B.2. I authorize the disclosure and/or use of the following information (collectively the "Application Information"):
(a) My FMLA request and all supporting documentation for time period (enter dates):_____;
(b) Charts and/or summaries created by the City showing my use of leave accruals;
(c) Sick Leave Donation form;
(d) Other information I submitted with my donation request (describe information in detail): _____
_____

B.3. I authorize the disclosure and/or use for the following reason(s):
(a) for review of sick leave donation request by the AFSCME Donation Committee
(b) for review by individual(s) wishing to donate sick leave

YOU MUST CONTINUE ON THE NEXT PAGE

READ SECTION C:

C. Right to Revoke:
I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must notify City Human Resources in writing.

YOU AND A WITNESS MUST SIGN IN SECTION D:

D. Authorization and Signature: I authorize the release of my confidential, protected health information, the "Application Information" as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient (unless the recipient is covered by Oregon law which prohibits redisclosure or other laws that limit the use and/or disclosure of my confidential protected health information). My employment or FMLA status is not conditioned on signing this authorization, but the information authorized is necessary for Donation Committee review of my request for sick leave donations.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential, protected health information.

_____ _____
Your Signature Date

_____ _____
Signature of Witness Date

COMPLETE SECTION E FOR A LEGAL/PERSONAL REPRESENTATIVE:

E. Legal Representative: If a Legal Representative (e.g., Guardian, Conservator, or Authorized Representative) on behalf of the individual signs this authorization, complete the following:

Legal Representative's Name & Title (PRINTED): _____

Legal Representative's Signature: _____

Date:_____ Daytime Phone Number:_____

1. If this authorization is being requested/signed by the Legal Representative, you must furnish a copy of the Power of Attorney or other relevant documents designating you as the representative of the member.
2. Please provide a copy of this form to your authorized representative so that they will be able to establish the validity of their request for your protected health information.

Complete, Sign and Return this form to: Human Resources, 500 Klamath Ave., Klamath Falls, OR 97601