Print Form

ALAMEDA COUNTY

CONSENT TO RELEASE FAMILY MEMBER'S MEDICAL INFORMATION

In connection with my family member's request for leave under the Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA) to provide care for my serious health condition, I hereby authorize my clinician _____, to release to Alameda County specific medical information necessary to approve my family member's request for Family and Medical Leave (FML). The attached County of Alameda Family and Medical Leave - Certification of Health Care Provider form outlines the required information.

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.

Please send the requested information to:

Fax:	Phone:

I understand the following:

- This authorization to use or disclose my medical information pertains to my family member's request for family and medical leave as described above is being voluntarily signed.
- This release will remain valid through the completion of my family member's family and medical leave or until 12 months from the date of signature unless a different date is specified here _____.
- A copy of this authorization is as valid as the original, and I am aware that I have a right to a copy of this authorization.
- I have the right to revoke this authorization at any time by providing written notification to the person and location identified directly above. The revocation will become effective on the date my request is received, except to the extent that the disclosing party or others have acted in reliance on the authorization.

My relationship to the employee is: _____. I hereby consent to have my clinician release specific information regarding my medical condition to my family member's employer, Alameda County.

Print Family Member's Name:	*Signature:*	*Date:*
Print Employee's Name:	*Signature:*	*Date:*