

**HIPAA Authorization for Release of Information to UCA For Family  
Medical Leave Act (FMLA) Purposes Only**

I,

\_\_\_\_\_  
*Print Name of Patient or Patient's Legal Representative Authorized to Act on Behalf of the Patient*

hereby authorize the following healthcare provider to release to UCA the health information as stated below.

**Health Information From:**

Physician/Clinic/Healthcare Provider (name and address) \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

**Health Information About:**

Patient Name \_\_\_\_\_

Employee Name (if different from patient): \_\_\_\_\_

**Purpose of Release:** Leave requested under FMLA based on health condition of

self  child  spouse  parent (check one)

**Release to:**           **University of Central Arkansas (UCA)**

Human Resources

201 Donaghey Ave

Wingo 106

Conway, AR 72035

Phone (501) 852-2562 Fax (501) 450-5088

**Information to be released: Information is to be limited to reason employee is requesting leave under FMLA.**

**Expiration of Authorization:** This authorization will expire one year from the date on which it is signed or when I am no longer requesting leave under FMLA, whichever is later.

**Withdrawal of Authorization:** I understand that I may withdraw or revoke this authorization at any time by giving written notice to my healthcare provider designated above. A withdrawal of this authorization will not apply to records/information already released in reliance upon the authorization.

**Re-disclosure:** I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulation.

A photocopy or faxed copy of this signed authorization shall constitute a valid authorization.

I understand that the healthcare provider who is releasing this information to UCA/ my employer will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date

**If Legal Representative is signing for patient,** state the relationship/authority of Legal Representative:

\_\_\_\_\_  
(Such as parent of minor, court-appointed guardian)