Delaware Department of Human Resources

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI) FORM AMERICANS WITH DISABILITIES ACT[1] (ADA)- Statewide	
DHR-STW-Form #: DHR-STW-201.1-F1	**Authority: Americans with Disabilities Act of 2008 (ADA); 42 U.S.C. § 21G Pregnant Workers Fairness Act; 29 U.S.C. §218d PUMP for Nursing Mothers Act; 19 Del. C. §§ 710, 711, 716**
Effective Date: September 1, 2020	**Revision Date: December 1, 2023**
Supersedes: N/A	

This form is to be completed only when additional documentation is requested by the employer. Circumstances may include requests to the healthcare provider for additional documentation, recommended accommodations, and/or requests to contact the provider for clarification on questions already completed on Americans with Disabilities Act (ADA) forms.

Part 1: Employee Information

Employee Name: _____ Job Title: _____

Department/Agency: _____ Unit/Facility: _____

Email Address: _____ Phone Number: _____

Part 2: Person or Entity that Has the Health Information to be Released

Healthcare Provider: _____

Address: _____Phone Number: _____

(Print the name and address of the provider that has the record to be disclosed, e.g., Dr. Jane Doe, ABC Laboratories, XYZ Hospital, etc. If you need to list more than one healthcare provider, please provide an extra page with that information.)

Part 3: Description of Health Information to be Released

☐ My health information and medical records related to the request of reasonable accommodation(s).

☐ Other: _____

(Describe health information that may be disclosed. Medical diagnosis is not requested.

Signature: _____ Date: _____

[1] While pregnancy itself is not a disability under the ADA, some pregnant workers may have one or more impairments related to their pregnancy that qualify as a "disability" under the ADA.

Part 4: Person or Entity that Will Receive the Health Information

☐ Agency ADA Coordinator; or

☐ Human Resources Representative or Designee

Name: _____ Department: _____

Address: _____

Part 5: Description of the Purpose of the Health Information

To support my request for a reasonable accommodation under the ADA.

Signature: _____ Date: _____

Part 6: Duration of Authorization

Expiration period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ _____ days, or

☐ Expiration event: The date the State of Delaware makes a final determination about my request.

Part 7: Certification and Acknowledgment

I certify that I am the person (or the personal representative of the person) designated in Part 1. I agree that my individually identifiable health information described in Part 3 and held by the person or entity listed in Part 2 may be disclosed to the person or entity listed in Part 4 for the purpose(s) designated in Part 5.

I understand that the healthcare provider(s) listed in Part 2 and/or the State of Delaware Employee Health Care Plan will not condition treatment, payment, enrollment or eligibility on the provision of this Authorization. However, I understand that the State of Delaware may deny my request if I fail to sign this Authorization and provide my health information that is necessary to support my request. I understand that I have the right to revoke this Authorization, in writing, at any time, by sending the revocation to the person or entity authorized to release the information in Part 2, and that the revocation will be effective except to the extent that the person or entity releasing the information has already taken action in reliance on my Authorization.

I also understand that, if I revoke this Authorization and therefore do not provide the State of Delaware with the information necessary to support my request, the State of Delaware may deny my request. I understand that once disclosed, it is possible that the health information may be further disclosed by the recipient and is no longer subject to protection under federal HIPAA privacy rules. However, I also understand that the recipient will protect my health information in accordance with other applicable laws and the State of Delaware's internal privacy policies.

☐ **I have received a copy of my signed Authorization.**

Signature: _____ Date: _____

If signing as the personal representative of the person in Box 1, print your name and describe your authority to sign for the person:

Name: _____ Date: _____

Authority: _____

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purpose of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A may be provided by checking a box as indicated, electronic initials or name, or email confirmation.