Bonner County Medical Release & Authorization for COVID19 Medical Inquiry

Please fax or mail completed paperwork to:
Bonner County Human Resources
1500 Hwy 2, #337, Sandpoint, ID 83864
Fax: 208-265-1457
Phone: 208-265-1456
Email: hr@bonnercountyid.gov

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the use or release/disclosure of protected health information regarding the named individual as described below.

Patient's Full Name (Including maiden name)

Have you been here under any other names(s)?

Job Title

The following person or organization is authorized to DISCLOSE the specified information:

Name: _____

Street Address:_____

City, State, Zip:_____

Phone Number:_____

The following designated person for the Employer is authorized to RECEIVE the information:

Name: BONNER COUNTY HUMAN RESOURCES

Street Address: 1500 HIGHWAY 2, SUITE 337

City, State, Zip: SANDPOINT, ID 83864

Phone Number: 208-265-1456 Fax Number: 208-265-1457

This information is to be used for the following purpose(s) only: COVID19

The specific information to be released/disclosed is specified below. The medical provider is released to both discuss this case with the designated person for the Employer listed above and to provide written responses to inquiries regarding reasonable accommodation of the patient at their place of work. The following diagnoses/conditions are indicated by the employee:_____

Authorization to release requested health information:

Signature of EMPLOYEE/PATIENT: _____ **Date:** _____

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the Bonner County Non FMLA Personal Leave Policy. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine leave coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____

Fax:(_____)_____

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MEDICAL FACTS

1. Approximate date condition commenced: _____
2. Probable duration of condition: _____
3. Expected Date to return to work:_____

Mark below as applicable:

- ☐ the employee/family member is subject to a federal, state, or local quarantine or isolation order related to COVID-19
- ☐ the employee/family member has been advised by a health care provider to self-quarantine because of COVID-19
- ☐ the employee/family member is experiencing symptoms of COVID-19 and is seeking a medical diagnosis
- ☐ the employee is caring for an individual subject or advised to quarantine or isolation
- ☐ the employee is experiencing substantially similar conditions as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury

Signature of Health Care Provider: _____ Date: _____