Prudential

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/mybenefits

Release of Personal Health Information Under the NY Paid Family Leave (PFL) Law (Based on Form PFL-3)

Instructions Included with Form

TO BE COMPLETED BY THE EMPLOYEE

Employee's name

_____
(first name, middle initial, last name)

Care Recipient's (patient's) name

_____
(first name, middle initial, last name)

Control Number **Prudential Claim Number**

Care recipient's (patient's) date of birth
(MM/DD/YYYY)
__ __ / __ __ / __ __ __ __

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be signed by the health care recipient or authorized representative and submitted to care recipient's health care provider with GL.2017.188 or NY Form PFL-4)

I, _____, authorize my health care provider listed on this form to release my personal health
Care recipient's (patient's) name

information to _____ and their employer's PFL insurance carrier **Prudential** .
Employee's name PFL insurance carrier's name

Records Subject to Release: This form gives the health care provider listed permission to include information from your health care records on the attached medical certification. This form gives your health care provider permission to release only the information in your health care records that relate to your current condition, which is the subject of the employee's request for Paid Family Leave benefits.

Duration of Revocable Release: This authorization ends after **one year**, or when you revoke the release. You can cancel this release at any time. To cancel, send a letter to the health care provider listed on this form.

This form does NOT allow your health care provider to release the following types of information, unless you specifically permit such release. Put an "X" next to any information your health provider MAY release:

☐ HIV/AIDS related information ☐ Mental health information ☐ Alcohol/drug treatment ☐ Psychotherapy notes

Health Care Provider Information (to be completed by the care recipient or authorized representative)

Identify the health care provider who is currently providing you with treatment for a condition that is subject to the employee's request for PFL benefits.

1. Health care provider's name _____

2. Health care provider's mailing address

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

3. Health care provider's telephone number (provide area or country code)

_____

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RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be signed by the health care recipient or authorized representative and submitted to care recipient's health care provider with GL.2017.188 or NY Form PFL-4)

Care Recipient Information

4. Care recipient's mailing address

_____
Mailing address

_____
City, state, zip code, country (if not U.S.A.)

5. Care recipient's Social Security number (if applicable)

__ __ __ - __ __ - __ __ __ __

6. Care recipient's telephone number (provide area or country code)

_____

READ AND SIGN BELOW. I hereby request that the health care provider listed above give a completed Request for NY Paid Family Leave (PFL) Health Care Provider Certification of Care of Family Member with Serious Health Condition (GL.2017.188 or NY Form PFL-4) to the employee identified on the GL.2017.188 or NY Form PFL-4. I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and any estimation of the amount of care that I require from the employee requesting PFL benefits as a result of my current condition.

_____ __ __ / __ __ / __ __ __ __
Care recipient's signature Date signed (MM/DD/YYYY)

Authorized representative

I, _____ , represent the care recipient in this matter as authorized by:
Print name

☐ Parental right ☐ Power of attorney (attach copy) ☐ Court order (attach copy) ☐ Health care proxy (attach copy)

_____ __ __ / __ __ / __ __ __ __
Authorized representative's signature Date signed (MM/DD/YYYY)

The employee should retain a copy for their own records.

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Instructions

If an employee is requesting PFL to care for a family member with a serious health condition, the care recipient or an authorized representative must complete a *Release Of Personal Health Information Under The NY Paid Family Leave Law (GL.2017.187 or NY Form PFL-3)* and submit it to his or her health care provider, along with a copy of the *Request for NY Paid Family Leave (PFL) Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or NY Form PFL-4)*.

Before completing and signing, the care recipient must read the *Release Of Personal Health Information Under The NY Paid Family Leave Law (GL.2017.187 or NY Form PFL-3)* in its entirety.

The *Release Of Personal Health Information Under The NY Paid Family Leave Law (GL.2017.187 or NY Form PFL-3)* enables the health care provider to complete *Request for NY Paid Family Leave (PFL) Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or NY Form PFL-4)* and release it to the employee seeking PFL benefits. The employee requesting PFL then submits both the Request for NY Paid Family Leave (PFL) (GL.2017.178 or NY PFL-1) and the *Request for NY Paid Family Leave (PFL) Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or NY Form PFL-4)* to their employer's PFL insurance carrier, or to their employer if the employer is self-insured, for PFL benefit determination.

NOTE: This form will be retained by the health care provider. The employee should make a copy for his or her records before giving it to the health care provider.

Care recipient or authorized representative signs and dates.
This form is given to the care recipient's health care provider along with the *Request for NY Paid Family Leave (PFL) Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or NY Form PFL-4).*

RELEASE OF PERSONAL HEALTH INFORMATION BY THE HEALTH CARE PROVIDER FOR A FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION (to be completed by care recipient or authorized representative and submitted to care recipient's health care provider with GL.2017.188 or NY Form PFL-4)

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request for NY Paid Family Leave (PFL) (GL.2017.178 or NY Form PFL -1)* Part B line 13.

Care recipient or authorized representative must complete all applicable requested information.

If a care recipient is unable to fill out this form, an authorized representative must attach a copy of legal documentation, such as a health care proxy or power of attorney, permitting the representative to sign on behalf of the care recipient. The health care provider will require this documentation of authorization unless the authorized representative is a parent signing on behalf of a minor child.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.