AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TO: Dr. Amanda Hollingsworth (Medical Provider's Name)
1700 N. Oregon St. #530 (Street Address)
El Paso, Texas 79902 (City/State/Zip)

1. **Authorization:** I hereby authorize you and/or your staff to release all protected health information ("PHI") related to my eligibility for paid medical leave benefits and/or my potential need for a reasonable accommodation regarding my employment to UHS and its designated agents for leave administration and coordination with other benefit plans. This authorization applies to all medical and non-medical information that is needed by UHS, its parent, subsidiaries and affiliates, its administrators including Sedgwick CMS, and its insurers, related to any of the following: request for reasonable accommodation; workers' compensation claim; claim for disability benefits; claim for FMLA; or claim for leave.

2. **Notice Regarding Nondisclosure of Genetic 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, I am 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.

3. **Purpose of the Disclosure:** To permit the recipient to evaluate my ability to perform the essential functions of my position, my eligibility for paid medical leave benefits and/or my potential need for a reasonable accommodation.

4. **Revocation Rights:** I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to the health care provider identified above. I understand that the revocation will become effective upon receipt. I understand that any PHI disclosed pursuant to this Authorization before the effective date of a revocation will not be subject to the revocation.

5. **Further Disclosure:** I understand that once the health care provider identified above discloses PHI pursuant to this Authorization, the PHI may no longer be protected under federal law, and the recipient may further disclose the PHI which it receives pursuant to this Authorization unless barred from doing so by applicable state law.

6. **Expiration Date:** I understand that this Authorization will expire one year from the date below.

7. I understand that the health care provider listed above may condition treatment on my signing this Authorization.

8. I understand that I am entitled to receive a paper copy of this Authorization upon request.

Signature: Sara Martine Print Name: SARA MARTINE Date: 11/13/2020

Phone Number: (915) 787-0300 Personal E-mail: saramartine2584@gmail.com

If signed by personal representative, describe the relationship or authority of personal representative:

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