Authorization for Disclosure of Information - IRS Return Preparer Office

Department of Health and Human Services, Federal Occupational Health (FOH) Services

The use of this form is voluntary. This form is used by FOH to obtain medical certification related to your Reasonable Accommodation request from your health care provider. By providing the information requested on this form, FOH will be able to obtain information from your medical provider. FOH will use this medical information to develop a recommendation for your reasonable accommodation request. FOH will only share the necessary medical information required to make a decision on your request. All other medical documentation will be kept in your case file at FOH.

SECTION 1 Testing Candidate's Information

Name of candidate (*Last, First, Middle Initial*)

Last 4 digits of SSN	Gender	Date of birth *(mm-dd-yyyy)*	Telephone number *(include area code)*
	☐ Male ☐ Female		

Address *(street address - no P.O. Boxes)*

City	State	ZIP code

SECTION 2 Treating Health Care Provider Contact Information

Name of health care provider

Mailing address *(street address - no P.O. Boxes)*

City	State	ZIP code

Office telephone number *(include area code)*	Office FAX number *(include area code)*

SECTION 3 Instructions for the Treating Health Care Provider

Your patient is seeking a reasonable accommodation for testing accommodation for an examination administered by the Internal Revenue Service. FOH Services seeks your input as to condition, treatment, etc. Your response should be an assessment of your patient's request 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 the type of reasonable accommodation this patient is seeking. Limit your responses to the condition for which the patient is requesting reasonable accommodations for tax examination.

You are hereby authorized to furnish information from the record of the patient named below, which is in the record system of your facility, and release it to: **Federal Occupational Health (FOH) Services**, Bethesda, MD FAX number 301-594-3321

Name of patient	Agency

I authorize the disclosure of my medical information, related to to my reasonable accommodation request made on _____ to FOH Services. I am allowing my doctor or primary health care provider to release medical information pertaining to my condition for which I am seeking reasonable accommodation and only for medical records dated:

SECTION 4 Individual Signature

Name of patient	Patient signature	Date signed

This authorization expires one year from the date the patient signed this form in Section 4.

This authorization is subject to revocation by the individual at any time except to the extent that FOH has already taken action in reliance on it. If this authorization has not been revoked in writing, it will expire with the terms of the duration statement provided above. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor and fined not more than $5,000 (5 U.S.C 552a(i)(3)); in the case of alcohol and drug abuse patient records, a falsified authorization for disclosure is prohibited under 42 CFR 2.31 and is punishable by a fine of not more than $500 for a first offense or a fine of not more than $5,000 for a subsequent offense, in accordance with 42 CFR 2.4. The release of information about a patient who is treated or referred for treatment for alcohol or drug abuse, or the medical results of such abuse, is governed by the Confidentiality of Alcohol and Drug Abuse Patient Record Regulations, 42 CFR Part 2.

Privacy Act Notice

Effective March 1, 1999, it is the policy of FOH that all medical confidential information will be handled in accordance with **5 CFR Part 293** (Personnel Records), **5 CFR Part 297** (Privacy Provisions for Personnel Records), **5 USC 552a(b)**(Conditions of Disclosure), **OPM/GOVT-10** (Employee Medical File System Records, including authorized “Routine Uses” for those records), and the **Privacy Act of 1974** and subsequent amendments, as well as the guidance provided in 3.2 (above) by OSHA.