AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. **Authorization:** I, _____
   Print Your Name Here
   hereby authorize _____ to disclose to Brookhaven Science Associates, LLC
   Physician's Name
   the following protected health information ("PHI"), excluding psychotherapy notes:[1]

   Medical and non-medical information that is needed by Brookhaven Science Associates, LLC related to my request for a reasonable accommodation. The PHI to be disclosed includes, but it not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, records received from other health care providers, information regarding pre-existing health or medical conditions or illnesses, and occupation and employment activities.

2. **Purpose of The Disclosure:** To assist in assessing my ability to perform the essential functions of my job with or without reasonable accommodation(s).

   Notice To Provider: 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, you should 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. **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 in paragraph 1, 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.

4. **Further Disclosure:** I understand that once the health care provider identified in paragraph 1 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 received pursuant to this Authorization without my consent to the extent permitted by applicable law.

5. **Expiration Date:** I understand that this Authorization will expire upon the termination of my employment with Brookhaven Science Laboratories if not sooner revoked by me.

6. I understand that neither treatment, enrollment in the health plan, eligibility for benefits, nor payment will be conditioned on my signing this Authorization.

7. I understand that I am entitled to receive a copy of this Authorization after I have signed and dated it.

Signature: _____

Dated: _____

[1] The term "psychotherapy notes" means "notes recorded (in any medium) by a health care provider, who is a mental health professional, documenting or analyzing the contents of conversations during a private counseling session or group, joint, or family counseling session and that are separated from the rest of the individual's medical record."