Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3) 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 Paid Family Leave Law (Form PFL-3)* and submit it to their health care provider, along with a copy of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.
- The *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* enables the health care provider to complete *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* and release it to the employee seeking PFL benefits.
- Before completing and signing, the care recipient must read the *Release Of Personal Health Information Under The Paid Family Leave Law (Form PFL-3)* in its entirety.
- The employee requesting PFL submits both the *Request For Paid Family Leave (Form PFL-1)* and the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (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 their 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 *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (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 the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

Employee enters their name, and care recipient's (patient's) name and date of birth at the top of each page.

The PFL insurance carrier name requested at the top of the form is the same as the PFL insurance carrier identified in *Request For Paid Family Leave (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.

If you need assistance, please call (844) 337-6303
www.ny.gov/PaidFamilyLeave

DO NOT SCAN

NEW YORK STATE | Paid Family Leave

Standard Security Life Insurance Company
P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854
Email: claims@sslicny.com

Request For Paid Family Leave
Release Of Personal Health Information Under The Paid Family Leave Law (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)

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 completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4)

I, Care recipient's (patient's) name **, authorize my health care provider listed on this form to release my personal health information to** Employee's name **and their employer's PFL insurance carrier** PFL insurance carrier's name Standard Security Life Ins. Co. of NY **.**

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)

Form PFL-3 continued on next page

Standard Security Life Insurance Company P.O. Box 25339, Farmington, NY 14425
Phone: 800-477-0087 | Fax: 585-398-2854 | Email: claims@sslicny.com

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)

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 completed by the care recipient or authorized representative and submitted to care recipient's health care provider with Form PFL-4) - continued from prior page

Form PFL-3 continued from prior page

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

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** ___ - ___ - ____

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

READ AND SIGN BELOW

I hereby request that the health care provider listed give a completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the employee identified on the PFL-4 form. 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, Print name **, represent the care recipient in this matter as authorized by:**

☐ 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.