**Boston Scientific Corporation**

**EMPLOYEE AUTHORIZATION TO RELEASE**

**MEDICAL AND HEALTH CARE INFORMATION**

**Employee/Patient Name:**

**Last 4 digits of Employee/Patient SSN:**

*Boston Scientific requires information to evaluate your medical condition in connection with your employment. In order to obtain relevant information from your health care provider, it is necessary for you to sign this authorization form. We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information to the fullest extent possible. Please read the information below carefully before signing this form. If you have any questions, please contact [HRBP name].*

**USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION**

I authorize the individual or entity named below to disclose to Boston Scientific (including its benefit plan or claims administrators) any medical or other health care information relating to (Please specify each condition or impairment which is/are related to your current absence, including any applicable leave and/or accommodation request):

**HEALTH CARE PROVIDER INFORMATION**

|  |  |
| --- | --- |
| Health Care Provider/Institution Name: |  |
| Contact Name: |  |
| Address: |  |
| Phone Number: |  |
| Fax Number: |  |

**SPECIFIC UNDERSTANDINGS**

By signing this authorization form, I authorize the use or disclosure of my health information as described above. In accordance with applicable law, this information may be used by Boston Scientific and redisclosed to third parties, including when necessary to respond to any claims associated with the prior disclosure of the health information, and in that event such information may no longer be protected by the federal HIPAA privacy regulations or other law.

I understand that I have a right to refuse to sign this authorization. If I do not sign this form, I understand that it may adversely affect Boston Scientific’s ability to assess the underlying issue specified above, including but not limited to any related leave, absence and/or accommodation issues.

I understand that I have a right to see and copy the information described on this authorization. I also have a right to receive a copy of this form after I have signed it.

I authorize the use of a photocopy of this authorization in lieu of any original signature and agree that this authorization shall remain valid until otherwise revoked by me or until such time that Boston Scientific no longer needs to assess my medical information for the reason specified above. I understand that I also have the right to revoke this authorization at any time by written letter to the health care provider, Group Health Plan, or other entity I have authorized to release information. I understand that I may also revoke my consent to Boston Scientific’s redisclosure of information to third parties, except to the extent that the Company has acted in reliance on my authorization to use and disclose the information released. I understand that, in order to be effective, any revocation must be in writing and delivered to my Human Resources representative. Revoking this authorization does not affect the release of any information prior to my revocation. In addition, I understand that revoking this authorization may affect my right to a leave of absence, reasonable accommodation, return to work, or other job-related benefit.

**SIGNATURE**

*I have fully read this authorization form and had sufficient opportunity to ask any questions*

*before signing. By signing below, I acknowledge that I have read, fully understand and agree to all of the above.*

Print Name of Employee Authorizing Release of Medical Information

Signature of Employee Authorizing Release of Medical Information (or Personal Representative)

If signature is of Personal Representative, print name and explain his/her Relationship/Authority to the employee whose medical information is being released (*e.g., legal guardian)*

Date