MetLife

Request for New York Paid Family Leave

Release Of Personal Health Information (PHI)
Under The Paid Family Leave Law *(MET-PFL-3)*

Things to know before you begin

- This form will be retained by the health care provider. The employee should make a copy for his or her records before giving it to the health care provider.
- The employee should retain a copy for his or her own records.

Care recipient or authorized representative must complete all applicable requested information.

SECTION 1: To permit the release of personal health information by the health care provider for a family member with a serious health condition *(to be signed by the health care recipient)*

I, _____ *(Care recipient's name)*, authorize my health care provider listed on this form to release my personal health information to _____ *(Employee's name)* and MetLife.

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. Your health care provider may not, however, discuss your health care information with anyone.

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
- ☐ Alcohol/drug treatment
- ☐ Mental health information
- ☐ Psychotherapy notes

Health care provider information

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.

Health care provider's name

Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Phone number *(provide area or country code)*

Care recipient information

Care recipient - Mailing address	City	State	ZIP

Country *(if not U.S.A.)*

Social Security number *(if applicable)*	Phone number *(provide area or country code)*

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

SECTION 2: Signature

Read and sign below. I hereby request that the health care provider listed above give a completed MET-PFL-4 form to the person identified above. 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.

Sign Here Signature of Care recipient _____ Date *(mm/dd/yyyy)* _____

Authorized representative *(if applicable)*

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)*

Sign Here Signature of Authorized representative _____ Date *(mm/dd/yyyy)* _____

Release of Personal Health Information (PHI) under the Paid Family Leave Law *(MET-PFL-3)* form 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 *(MET-PFL-3)* and submit it to his or her health care provider, along with a copy of the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)*.

The Release Of Personal Health Information Under The Paid Family Leave Law *(MET-PFL-3)* enables the health care provider to complete Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* and release it to the employee seeking PFL benefits. The employee requesting PFL then submits both the MET-PFL-1 and the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* to MetLife Disability, P.O. Box 14590, Lexington, KY 40512, or by fax at 1-800-230-9531, for PFL benefit determination.

Before completing and signing, the care recipient must read the Release Of Personal Health Information Under The Paid Family Leave Law *(MET-PFL-3)* in its entirety.

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.

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 *(MET-PFL-4)*.

MetLife

Request for New York Paid Family Leave

Health Care Provider Certification of Care for Family Member
with Serious Health Condition *(MET-PFL-4)*

Things to know before you begin

- If you believe the care recipient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.
- The employee requesting PFL to care for a family member with a serious health condition must submit the Health Care Provider Certification For Care Of Family Member With Serious Health Condition *(MET-PFL-4)* with the Request For Paid Family Leave *(MET-PFL-1)*.

The care recipient's health care provider must complete all applicable requested information unless noted as optional.

To be completed by the Employee

Employee's first name	Middle initial	Last name

Employee's mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Social Security number	PFL claim number

SECTION 1: Health care provider certification for care of family member with serious health condition *(to be completed by the health care provider and returned to the aboved named employee)*

Patient information *(family member with serious health condition)*

First name	Middle initial	Last name

Date of birth *(mm/dd/yyyy)*

_____

Does patient require care by the employee requesting Paid Family Leave (PFL)?
(If no, skip to "Health Care Provider Information".) ☐ Yes ☐ No

For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

Primary ICD-10 code *(optional)*	Date patient's condition commenced *(mm/dd/yyyy)*

Diagnosis

First date care for patient is needed *(mm/dd/yyyy)*	Expected date patient will no longer require care *(mm/dd/yyyy)*

Estimated number of days per week OR days per month patient requires care

_____ Days/week OR _____ Days/month

Name of employee requesting PFL

First name	Middle initial	Last name	PFL claim number

Health care provider information

First name	Middle initial	Last name

Type of health care provider:

- ☐ Doctor of Osteopathy (DO)
- ☐ Medical Doctor (MD)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other *(specify)*

Mailing address	City	State	ZIP

Country *(if not U.S.A.)*	Phone number *(provide area or country code)*

Fax number	Email address *(if available)*	Specialty

State or country *(if not U.S.A.)* in which health care provider is licensed to practice	License number

SECTION 2: Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Sign Here	Signature of Health care provider	Date *(mm/dd/yyyy)*

Health Care Provider signs and dates, and then returns the form to the employee requesting PFL.