NATIONAL ASSOCIATION OF POSTAL SUPERVISORS
National Headquarters
1727 KING STREET, SUITE 400
ALEXANDRIA, VA 22314-2753
(703) 836-9660

November 27, 2024

Board Memo 182-2024: USPS Revisions to PS Form 2488

Executive Board,

The USPS has made substantial changes to PS Form 2488, Authorization to Use or Disclose Protected Health Information. Please find the revised form attached as well as the previous version of the form as a reference.

Please share with your membership.

Thank you and be safe.

NAPS Headquarters

LABOR RELATIONS

UNITED STATES POSTAL SERVICE

November 22, 2024

RECEIVED
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Mr. Ivan Butts
President
National Association of Postal Supervisors
1727 King Street, Suite 400
Alexandria, VA 22314-2753

Dear Ivan:

As a matter of general interest, the Postal Service has revised PS Form 2488, *Authorization to Use or Disclose Protected Health Information.*

The revisions to PS Form 2488 include the following:

- Identification of the reason for why the employee's medical/health information is being sought;
- Identification of the time period of the medical/health information being sought;
- Specific authorization for disclosure of sensitive information;
- New section providing notice that genetic information is not being sought and should not be provided;
- Updated Privacy Act statement;
- New "Employee Acknowledgements" section.

We have enclosed copies of the revised PS Form 2488, *Authorization to Use or Disclose Protected Health Information,* one with and one without changes identified.

Please contact Bruce Nicholson at extension 7773 if you have questions concerning this matter.

Sincerely,

for James Lloyd
Director
Contract Administration (NALC)

Enclosures

475 L'ENFANT PLAZA SW
WASHINGTON DC 20260-4101
WWW.USPS.COM

UNITED STATES POSTAL SERVICE®

Authorization to Use or Disclose Protected Health Information

Please print or type when completing this form.

I. POSTAL SERVICE™ REQUESTER/RECIPIENT OF INFORMATION (COMPLETE THIS SECTION FIRST)

Requester's Name (Last, First, MI)	Requester's Title

Requester's Address (Number, street, suite, etc.)

City	State	ZIP+4®	Requester's Office Telephone Number (Include Area Code and Extension)

The medical/health information indicated below from _____ (Beginning Date) to _____ (End Date) is being sought to assess:

- ☐ FMLA Request
- ☐ Review of Work Restrictions and Assignments
- ☐ Return to Work Assessment
- ☐ Fitness for Duty
- ☐ Reasonable Accommodation Request
- ☐ Other *(Description Required)* _____

II. APPLICANT/EMPLOYEE PERSONAL INFORMATION

Requested Protected Health Information to be Used or Disclosed (to be completed by requester/recipient prior to employee signature):

- ☐ Medical and work restrictions
- ☐ Documentation of FMLA Serious Health Condition
- ☐ Fitness for Duty Exam
- ☐ Alcohol Test
- ☐ Treatment and diagnostic records for (Description Required) _____
- ☐ Return to Work Exam
- ☐ New Hire Candidate Physical
- ☐ CDL Exam
- ☐ Documentation of Disability to Support Reasonable Accommodation Request
- ☐ Other (Description Required) _____

To authorize any of the following sensitive information disclosed, initial the applicable line(s) below (to be completed by employee):

_____ Sexually transmitted Diseases

_____ HIV/AIDS-related Treatment

_____ Reproductive Health Information

_____ Alcohol/Drug Abuse Treatment/Referral

_____ Mental Health (Other than Psychotherapy Notes)

_____ Other _____

_____ Psychotherapy Notes ONLY (by initialing this line I am waiving any psychotherapist-patient privilege)

I, (print employee name) _____, give permission to the health care provider named below to furnish to the United States Postal Service the above medical information.

Signature of Postal Service Employee or Applicant	Date (MM/DD/YYY)	EIN or SSN

III. AUTHORIZED HEALTH CARE PROVIDER

Provider's Name (Last, First, MI)	Provider's Type of Practice

Provider's Address (Number, street, suite, etc.)

City	State	ZIP+4	Provider's Office Telephone Number (Include Area Code and Extension)
Provider's Email Address			Provider's Office Fax Number (Include Code)

IV. NOTICE TO HEALTH CARE PROVIDER OF GINA EXCLUSIONS

Information to be Excluded from Response to this Authorization

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, we are asking that you do 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.

V. DISCLOSURE INFORMATION AND PRIVACY ACT STATEMENT

Re-Disclosure by Recipient

Information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy regulation. Nonetheless, all medical information disclosed to the Postal Service is protected by the Privacy Act and where applicable, the Rehabilitation Act. Therefore, medical information remains confidential and the Postal Service takes all appropriate measures to ensure the privacy of the information disclosed to it against unauthorized disclosures to any party who does not have legitimate need for it in the discharge of official business.

Right of Revocation

You have the right to end this authorization at any time by writing to the authorized health care provider at the office of the health care provider listed above and requesting revocation of your authorization to the Postal Service. If you make a request to end the authorization, it will be honored prospectively only and not affect disclosures or uses already made based upon your prior permission.

Expiration of Authorization

This authorization will expire 1 year from the date of signature.

Privacy Act Statement

The information provided will be used for hiring decisions, to determine fitness for duty, to make reasonable accommodation decisions, or to grant or deny official leave from duty. Collection is authorized by 39 USC 401, 410, 1001, 1005, and 1206.

Supplying the information is voluntary, but if not provided, you may not receive full consideration for employment or reasonable accommodations. We do not disclose your information to third parties without your consent, except to act on your behalf or request, or as legally required. This includes the following limited circumstances: to a congressional office on your behalf; to agents or contractors when necessary to fulfill a business function; to a U. S. Postal Service auditor; for law enforcement purposes; to labor organizations as required by applicable law; incident to legal proceedings involving the Postal Service; to government agencies in connection with decisions as necessary; to the Equal Employment Opportunity Commission (EEOC) when requested in connection with the investigation of a formal complaint; to the Merit Systems Protection Board or Office of Special Counsel for the purpose of litigation; and to a private treating physician and to medical personnel retained by the USPS for medical examinations or to treat health or physical conditions related to employment. For more information regarding our privacy policies visit *www.usps.com/privacypolicy*.

VI. EMPLOYEE ACKNOWLEDGEMENTS

_____ (Please Initial)	I understand that my protected medical/health information records are confidential and protected by the Privacy Act.
_____ (Please Initial)	I understand that by signing this authorization, I am allowing the release of my protected medical/health information.
_____ (Please Initial)	I understand that the information is being sought for the assessment and/or purpose noted above in Section II.
_____ (Please Initial)	I understand I have the right to request reasonable accommodations. See Handbook EL-307 for more details.
_____ (Please Initial)	I understand that this authorization is voluntary, and I may refuse to sign and/or limit the scope of any medical inquiry by the Postal Service.
_____ (Please Initial)	I understand that that I may refuse to sign this release; however, if I refuse to sign this release or if I limit the release such that information necessary for the Postal Service's noted assessment and/or purpose is not provided, I may not receive full consideration for the employment inquiry, benefit, or other purpose for which the medical/health information was sought. For example, where applicable, consideration of the issues of reasonable accommodations and/or work available within medical restrictions may be impeded, and/or official leave may not be granted.
_____ (Please Initial)	I understand that I have the right to revoke this authorization to release my protected medical/health information at any time by notifying the Postal Service in writing, with the understanding that previously disclosed information would not be subject to my notice of revocation of this authorization.

UNITED STATES POSTAL SERVICE®

Please print or type when completing this form

Authorization to Use or Disclose Protected Health Information

[redacted]

I,_____, give permission to the health care provider named below to furnish to the United States Postal Service® the following medical information.

Requester's Name *(Last, First, MI)*	Requester's Title

Requester's Address *(Number, street, suite, etc.)*

City	State	ZIP+4®	Requester's Office Telephone Number *(Include Area Code and Extension)*

The medical/health information indicated below from _____ (Beginning Date) to _____ (End Date) is being sought to assess:

☐ FMLA Request ☐ Review of Work Restrictions and Assignments ☐ Return to Work Assessment

☐ Fitness for Duty ☐ Reasonable Accommodation Request

☐ Other *(Description Required)* _____

☐ *Other (Description Required)* _____

Signature of USPS® Employee or Applicant Date *(MM/DD/YYYY)* EIN or SSN

[redacted]

Requester's Name *(Last, First, MI)* Requester's Title

Requester's Address *(Number, street, suite, etc.)*

City	State	ZIP+4®	Requester's Office Telephone Number *(Include Area Code and Extension)*

Requested Protected Health Information to be Used or Disclosed (to be completed by requester/recipient prior to employee signature):

☐ **Medical and work restrictions**

☐ **Documentation of FMLA Serious Health Condition**

☐ **Fitness for Duty Exam**

☐ **Alcohol Test**

☐ **Treatment and diagnostic records for (Description Required)** _____

☐ **Return to Work Exam**

☐ **New Hire Candidate Physical**

☐ **CDL Exam**

☐ **Documentation of Disability to Support Reasonable Accommodation Request**

☐ **Other (Description Required)** _____

To authorize any of the following sensitive information disclosed, initial the applicable line(s) below (*to be completed by employee):*

_____Sexually transmitted Diseases

_____HIV/AIDS-related Treatment

_____Reproductive Health Information

_____Alcohol/Drug Abuse Treatment/Referral

_____Mental Health (Other than Psychotherapy Notes)

_____Other _____

_____Psychotherapy Notes ONLY (by initialing this line I am waiving any psychotherapist-patient privilege)

I, (print employee name) _____ **, give permission to the health care provider named below to furnish to the United States Postal Service the above medical information.**

Signature of Postal Service Employee or Applicant	Date *(MM/DD/YYY)*	EIN or SSN

III. Authorized Health Care Provider

Provider's Name *(Last, First, MI)*			Provider's Type of Practice
Provider's Address *(Number, street, suite, etc.)*			
City	State	ZIP+4	Provider's Office Telephone Number *(Include Area Code and Extension)*
Provider's Email Address			Provider's Office Fax Number *(Include Area Code)*

IV.

~~**Re-Disclosure by Recipient**~~
~~Information disclosed as a result of this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPAA privacy regulation. Nonetheless, all medical information disclosed to the USPS is protected by the Privacy Act and where applicable, the Rehabilitation Act. Therefore, medical information remains confidential and the Postal Service takes all appropriate measures to ensure the privacy of the information disclosed to it against unauthorized disclosures to any party who does not have legitimate need for it in the discharge of official business.~~

~~**Right of Revocation**~~
~~You have the right to end this authorization at any time by writing to the authorized health care provider at the office of the health care provider listed above and requesting revocation of your authorization to the United States Postal Service. If you make a request to end the authorization, it will be honored prospectively only and not affect disclosures or uses already made based upon your prior permission.~~

~~**Expiration of Authorization**~~
~~This authorization will expire 1 year from the date of signature.~~

~~**Privacy Act Statement**~~
~~Your information will be used for hiring decisions; to determine fitness for duty; to make reasonable accommodation decisions; or to grant or deny~~

~~official leave from duty. Collection is authorized by 39 USC 401, 404, 410, 1001, 1003, 1005, and 1206; and 29 USC 2601 et seq. Providing the information is voluntary, but if not provided, you may not receive full consideration for employment or reasonable accommodations; your commercial driver's license may not be renewed; or official leave may not be granted. We may only disclose your information as follows: in relevant legal proceedings; to law enforcement when the USPS or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; and to the Merit Systems Protection Board or Office of Special Counsel~~**Information to be Excluded from Response to this Authorization**

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, we are asking that you do 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.

[redacted]

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Supplying the information is voluntary, but if not provided, you may not receive full consideration for employment or reasonable accommodations. We do not disclose your information to third parties without your consent, except to act on your behalf or request, or as legally required. This includes the following limited circumstances: to a congressional office on your behalf; to agents or contractors when necessary to fulfill a business function; to a U. S. Postal Service auditor; for law enforcement purposes; to labor organizations as required by applicable law; incident to legal proceedings involving the Postal Service; to government agencies in connection with decisions as necessary; to the Equal Employment Opportunity Commission (EEOC) when requested in connection with the investigation of a formal complaint; to the Merit Systems Protection Board or Office of Special Counsel for the purpose of litigation; and to a private treating physician and to medical personnel retained by the USPS for medical examinations or to treat health or physical conditions related to employment. For more information regarding our privacy policies visit www.usps.com/privacypolicy.

[redacted]

_____ I understand that my protected medical/health information records are confidential and protected by the Privacy Act.
(Please Initial)

_____ I understand that by signing this authorization, I am allowing the release of my protected medical/health information.
(Please Initial)

_____ I understand that the information is being sought for the assessment and/or purpose noted above in Section II.
(Please Initial)

_____ I understand I have the right to request reasonable accommodations. See Handbook EL-307 for more details.
(Please Initial)

_____ I understand that this authorization is voluntary, and I may refuse to sign and/or limit the scope of any medical inquiry by the Postal Service.

(Please Initial)

_____ I understand that that I may refuse to sign this release; however, if I refuse to sign this release or if I limit the release such that information necessary for the Postal Service's noted assessment and/or purpose is not provided, I may not receive full consideration for the employment inquiry, benefit, or other purpose for which the medical/health information was sought. For example, where applicable, consideration of the issues of reasonable accommodations and/or work available within medical restrictions may be impeded, and/or official leave may not be granted.

(Please Initial)

_____ I understand that I have the right to revoke this authorization to release my protected medical/health information at any time by notifying the Postal Service in **writing**, with the understanding that previously disclosed information would not be subject to my notice of revocation of this authorization.

(Please Initial)