Marathon Oil Company
Authorization Form to Use and Disclose Protected Health Information
PLEASE READ THIS DOCUMENT CAREFULLY

This is an authorization form that will permit **your health care provider** to use or disclose some of your protected health information to Marathon Oil Company (the "Company"). You have the right to revoke this authorization at any time by sending a *written* revocation to your health care provider. Your revocation will not apply, however, to uses and disclosures your health care provider has already made in reliance on your authorization. Your ability to enroll and receive benefits under group medical plans, such as the Health Plan of Marathon Oil Company, or receive medical treatment through a group medical plan, is not be affected by refusing to sign an Authorization.

Name: _____ Soc. Sec. Number: _____

I authorize the following health care provider(s) and health care facilities:

_____

_____

to use and disclose the following health information about me:

_____

_____

_____

to **Marathon Oil Company Health Services ("Health Services")**, third party administrators of the Company's benefit plans, health care professionals retained to assist and advise the Company regarding the administration of the Company's employee benefit plans and employment practices, its attorneys and others retained to assist in determinations made by Health Services and the Company's Absence Management Advisory Team.

This use or disclosure is for the following purpose or purposes:

- To evaluate my ability to perform the essential functions of my job including, but not limited to, my ability to do so safely.
- To evaluate my ability to return to employment.
- To assist in determining my eligibility for benefits under the Sick Pay Plan and my eligibility under the Sick Leave Policy.
- To evaluate any Workers' Compensation claims (or claims under other similar government sponsored disability type programs) that I might assert.
- To assist in determining my eligibility for benefits under the Long Term Disability Plan.

This authorization is valid until _____/_____/_____.

Please Read Carefully and Sign

I understand that the health care provider described above will use or disclose the health information as described above until this authorization expires. I understand that I will receive a copy of this signed authorization for my records. I also understand that any health information released pursuant to this authorization might be re-disclosed by the recipient, and that any such re-disclosure may not be protected by HIPAA privacy regulation 45 CFR§164.508(b).

_____ _____ _____

Signature Employee Number Date

IMPORTANT NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with this law, we are asking that you 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).

Eff: 1-1-11

This Authorization is intended to comply with the Privacy Rule regulations on Authorizations for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) found at 45 CFR §164.508(b).