Medical Records Release Statement

HEALTHCARE PROFESSIONAL AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I _____, acknowledge and understand that the Company
Healthcare Professional Name (please print)

and its client facilities require medical documentation reasonably necessary to make decisions regarding my employment. I agree to provide all requested medical documentation relating to any requested or required accommodation to the Company. I authorize the Company to share requested medical documentation with the Company's affiliates and client facility(ies) to which I am assigned. Neither the Company nor its client facility(ies) will further disclose medical documentation released pursuant to this authorization, unless further expressly authorized by me or required by law. This authorization shall become effective immediately and shall remain in effect for three (3) years. I understand that I have the right to receive a copy of this authorization upon request.

_____ _____ _____
Signature of Healthcare Professional Healthcare Professional ID # Date

Work Related Allergies and Accommodations, one box must be checked

☐ **None**

☐ **Powder** (if checked, mark appropriate accommodation below)

☐ **Latex** (if checked, mark appropriate accommodation below)

☐ **Other**

Please explain:

_____
_____
_____
_____
_____
_____

Accommodations/Limitations: (Required if powder/latex/other were checked- check all that apply below)

☐ Latex Free Gloves ☐ Powder Free Gloves ☐ Latex & Powder Free Gloves

GLOVE SIZE: **Small** ☐ **Medium** ☐ **Large** ☐