OSF
ST. JOSEPH
MEDICAL CENTER

_____
MRN (Office Use ONLY)

Authorization for Release of Occupational Health Information

INSTRUCTIONS: Please fill in all information, sign, and date. Failure to do so may prevent or delay release of information.

_____ _____
Patient Name – Please Print Birth Date

_____ _____
Street Address City/State/Zip

_____ _____
SS Number Phone Number

I hereby authorize:

OSF Occupational Health
1505 Eastland Drive, Suite 1000
Bloomington, IL 61701

To Disclose to:

_____
Employer Name/Organization

_____
Street Address

_____
City/State/Zip Phone

The nature of the information to be used or disclosed is specified below. The use or disclosure will not include any Genetic or HIV/AIDS information *unless requested specifically by checking these boxes*:

☐ All Records Related to Your Care from (date) _____ to _____; OR

☐ Records (as checked below) during the period from (date) _____
(Check all that apply)

☐ Drug and/or Alcohol Test Results (includes post accident test) ☐ Genetic Information

☐ History/Physical Results (i.e. Release to Work) ☐ HIV / AIDS Info

☐ Pre-Employment Test Results as Required by Prospective Employer ☐ STD Information

☐ Work Comp Records for Injury/Illness Date of _____/ _____/ _____ (whether now existing or hereafter created)

☐ Other: _____

This disclosure will be made for the purpose(s) of: _____

For Patient – "I understand that:

- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that this authorization is voluntary. I understand that the person(s) or organization(s) authorized to make requested use and/or disclosure may not condition the provision of treatment on the provision of an authorization.
- I understand that I may revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to OSF Occupational Health. I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on the following date or event: termination from company listed about. If I do not specify an expiration date or event, this authorization will expire 12 months from the signature date."

_____ _____
Patient Signature Date

Parent/Guardian Name and Relationship (please print)_____

_____ _____
Parent/Guardian Signature Date

√ *(check one)* ☐ Please mail to disclosure address above ☐ Please notify when records are ready to pick up

_____ _____
Staff Witness Name (please print) Staff Signature

Occ Health Originally Created: 11/05