



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:

To Disclose to:

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

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