Patient Authorization to Release Medical Records or Disclosure of Protected Health Information to Employer

Patient Name: _____

Date of Birth: _____ SSN: _____

Name of Individual Authorizing Release: _____

Relationship to Patient:

- ☐ Self
- ☐ Parent/Guardian of minor
- ☐ Legal Counsel – Provide copy of legal representation document
- ☐ Other - Specify: _____

Purpose of the Release: At the Request of the Employer ***(Please initial to acknowledge purpose of release.)***

_____ *I hereby authorize you to release my medical records and/or drug and alcohol test results and any related documents that must be retained, according to Federal and State Regulations, to my employer (or employer's agent) indicated below.*

For DOT Physicals:

_____ *I hereby authorize you to release the Long Form of my DOT Physical and any related documents that must be retained, according to Federal and State Regulations, to my employer (or employer's agent) indicated below.*

Employer Name/Agent: _____

Employer Address: _____

I understand that, in compliance with Privacy Act regulations (45 CFR 164.508(c)),

- I request and authorize release of medical records and/or medical information to the above named party or party's agent.
- This release is voluntary and I have the right to revoke this authorization at any time. My revocation must be provided to you in writing.
- I may refuse to sign this authorization. However, if I refuse to sign this authorization, no services will be provided because the services are requested for the sole purpose of disclosure to a third party.
- If I authorize my protected health information to be disclosed to someone who is not required to comply with Federal Privacy Protection Regulations, then such information may be re-disclosed and would no longer be protected.
- I have a right to inspect and receive a copy of my own protected health information.
- I have a right to a signed copy of this authorization.

This authorization shall expire on _____ or one year from the authorization date listed below, whichever comes first.

_____ _____

Signature of Patient/Patient Representative *Date*