AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that once the information is released, it may no longer be protected by federal privacy regulations.

Employee Name (PRINT):_____

Persons/organizations providing the information

_____

_____

_____

_____

Person/Organizations receiving the information:
Shared Services Claims Department

Specific description of information (including date(s)): ALL RECORDS, FINDINGS, REPORTS RELATING TO INDIVIDUAL "CURRENT AND PRIOR MEDICAL CONDITIONS WHICH MAY RELATE TO INDIVIDUAL" PRESENT PARTIAL OR TOTAL INCAPACITY, REQUEST FOR LEAVE, LIGHT DUTY AND/OR WORK RESTRICTIONS

Purpose of Disclosure: ADMINISTRATION OF LEAVE POLICIES, ADMINISTRATION OF BENEFITS AND/OR COORDINATION OF RETURN TO WORK

The patient or the patient's representative must read and initial the following statements:

a. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

b. I understand that this authorization will expire upon the employee's release from care.

c. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

X_____ _____
Signature of Employee Date