Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ SS#: _____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

I hereby authorize medALERT Occupational Management Inc. **to use or disclose my protected health information as indicated below to:**

RECEIVING Institution: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

- ☐ Date Range (from: _____ to: _____)
- ☐ History and physical exam _____
- ☐ Lab Report _____
- ☐ X-ray Report _____
- ☐ Consultation Report _____
- ☐ Other: _____
- ☐ Clinic visits / treatment _____
- ☐ Emergency Room _____
- ☐ Operative Report _____
- ☐ Pathology Report _____
- ☐ Discharge Summary _____

PURPOSE OF DISCLOSURE:

- ☐ Changing physicians
- ☐ Continuing care
- ☐ At my (patient) request
- ☐ Workers' Compensation
- ☐ Other: _____
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School

1. I understand that, unless otherwise specified, this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
   - Substance abuse (including alcohol/drug abuse)
   - Mental health
   - Psychotherapy notes
   - HIV related information (including AIDS-related testing)

   The confidentiality of this information is required under Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in this statute.

2. I understand that this authorization will expire within _____ months from the date hereof unless otherwise specified (not to exceed 30 months). A photocopy of this form will be considered as valid as the original.

3. I understand that I may revoke this authorization at any time by notifying the healthcare facility's Privacy Officer in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

4. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

5. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

6. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

7. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
SIGNATURE OF PATIENT DATE
OR PATIENT'S AUTHORIZED REPRESENTATIVE

IF NOT SIGNED BY PATIENT, INDICATE RELATIONSHIP TO PATIENT OR OTHER AUTHORITY TO ACT: _____