

Federal Occupational Health
 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN – PRINT LEGIBLY AND USE BLACK OR BLUE INK

I, _____, hereby voluntarily authorize the disclosure of information from my health record.	
II. THIS INFORMATION IS TO BE DISCLOSED BY:	PROVIDED TO: (Agency, Medical Provider, Individual)
Name: Address: Phone: Fax: Email Address:	Name: Address: Phone: Fax: Email Address:
III. THE PURPOSE OR NEED FOR DISCLOSURE IS (check the applicable box): <input type="checkbox"/> Medical Services <input type="checkbox"/> Personal Use <input type="checkbox"/> Attorney <input type="checkbox"/> Disability/Reasonable Accommodation <input type="checkbox"/> Leave Bank/FMLA <input type="checkbox"/> Other (specify) _____	
IV. THE INFORMATION IS TO BE DISCLOSED FROM MY HEALTH RECORD (check appropriate box(es)): <input type="checkbox"/> Work-related clearance, problems, or restrictions <i>(If Sensitive Health Information is required, the client MUST select the applicable box in Sensitive Health Section V).</i> <input type="checkbox"/> Only the period of events from _____ to _____ <input type="checkbox"/> Only information related to _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Entire Record	
V. SENSITIVE HEALTH INFORMATION: CHECK THE APPLICABLE BOX(ES) BELOW IF ANY OF THESE ARE TO BE DISCLOSED. <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> HIV Status/AIDS and related treatment <input type="checkbox"/> Mental Health (other than psychotherapy notes)	
VI. DISCLOSURE AUTHORIZATION: SIGNATURE, DATE, AND VERIFICATION: (Authorization is incomplete without signature and date).	
I understand that I may revoke this authorization by submitting a revocation notice in writing at any time to Federal Occupational Health, except to the extent that action has been taken in reliance on this authorization. If this authorization is requested as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim. If this authorization has not been revoked, it will terminate six months from the date of my signature unless a different expiration date is specified below. (Specify New Date) _____	
I understand that FOH will not condition treatment or eligibility for care on my providing this authorization except if such care is provided solely for the purpose of creating Protected Health Information for disclosure to a third party.	
SIGNATURE OF CLIENT OR PERSONAL REPRESENTATIVE (state relationship to client)	DATE
SIGNATURE OF WITNESS (if required)	DATE
<i>This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a (i)(3)).</i>	
Client Identification #/Verification Type :	Request Processed By:
Client Name (Last, First, MI):	Date Completed (MM/DD/YYYY):
Date of Birth (MM/DD/YYYY):	How was information provided : <input type="checkbox"/> USPS <input type="checkbox"/> UPS <input type="checkbox"/> Fax <input type="checkbox"/> In-Person <input type="checkbox"/> E-mail
Client Address:	Attach Recipient confirmation (USPS return receipt/fax confirmation):