

AUTHORIZATION TO DISCLOSE HEALTH RELATED INFORMATION

For reasons pertaining to my potential or actu	ial employment, I hereby re	equest and	authorize North Oaks H	lealth Sys	tem to	disclos	e any and
all health related information relating to my visit on			The information will be disclosed at my request.				
REQUESTOR:							
Name:			Date of Birth:				
Address:							
City:	State:		Zip Code:				
SSN:	Telephone #: ()	MR#:				
TO MY POTENTIAL OR ACTUAL EMPLOYER Name:	•						
Address:							
City:	State:		Zip Code:				
I understand that I am authorizing the release requested by my Potential or Actual Employer Diagnostic Test Results (including, but not lim results), d) History and Physical), e) Progress may include results from Acquired Immunode the fact that I previously received Treatment of Health System by me or my potential or actual I understand that the health-related informa Potential or Actual Employer and may not be I understand that I may refuse to sign this A from Acquired Immunodeficiency Syndrome that I previously received Treatment for Alcounderstand that while my refusal to either so Immunodeficiency Syndrome (AIDS) or Humpreviously-received treatment for Alcohol a my potential or actual employment status, it I understand that I may revoke this Authoriz North Oaks Health System . I understand that	r as well as any or all of the ited to, radiographic, EKG, Notes, f) Provider/Nurses I efficiency Syndrome (AIDS) for Alcohol and/or Drug Abil employer) and information tion released as a result of protected by Federal/Stauthorization. I also have the (AIDS) or Human Immunional and/or Drug Abuse and information or a nan Immunodeficiency Virnd/or Drug Abuse and information in writing at any time at any information previous	e following: pulmonary Notes and (or Human use (where n regarding of this Auth ate Regulat the right to a odeficience and informa uthorize re rus (HIV) In- ormation re my ability to e. Revocati usly authori	a) Record Face Sheet, function, respiratory a Dpinions. I further und mmunodeficiency Virusuch information has Communicable Diseasorization may be rediions. Tefuse to disclose information regarding Commulease of information regarding Communicable obtain other medical on will be effective with the control of the control	b) Physic and drug ar erstand the s (HIV) Interest comments. sclosed comments comme	ian Orcind/or a lat rele fection munical or shar elating esting, bisease Acquirethat I e may sary cally rot be rot be rot or shar elating esting.	ders, c) llcohol-reased information inform	Lab and related test formation I testing, North Oaks If the testing t
written revocation of this Authorization. This	s Authorization shall autor	matically e	kpire one (1) year afte	r the date	indica	ated bel	ow.
Patient's Printed Name	Signature of Patient			Date	J I		
Personal Representative Printed Name	Signature of Persona	l Represen	tative	Date	J		
Reason patient cannot sign:							
Employee's Signature							

NS# 4949 • 1/11/16 Patient Services/Compliance

Doc Type: Release of Information

Scan Location: Patient Level

4949

Description: Authorization Disclose Health Related Information