NorthOaks Health System

AUTHORIZATION TO DISCLOSE HEALTH RELATED INFORMATION

For reasons pertaining to my potential or actual employment, I hereby request and authorize North Oaks Health System to disclose 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 #: (_____) _____ Email:_____

TO MY POTENTIAL OR ACTUAL EMPLOYER WHO/WHICH IS:

Name:_____

Address:_____

City: _____ State:_____ Zip Code:_____

I understand that I am authorizing the release of health related information, which includes the results of all examinations and tests requested by my Potential or Actual Employer as well as any or all of the following: a) Record Face Sheet, b) Physician Orders, c) Lab and Diagnostic Test Results (including, but not limited to, radiographic, EKG, pulmonary function, respiratory and drug and/or alcohol-related test results), d) History and Physical), e) Progress Notes, f) Provider/Nurses Notes and Opinions. I further understand that released information may include results from Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection-related testing, the fact that I previously received Treatment for Alcohol and/or Drug Abuse (where such information has been communicated to North Oaks Health System by me or my potential or actual employer) and information regarding Communicable Diseases.

I understand that the health-related information released as a result of this Authorization may be re-disclosed or shared by my Potential or Actual Employer and may not be protected by Federal/State Regulations.

I understand that I may refuse to sign this Authorization. I also have the right to refuse to disclose information relating to results from Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection-related testing, the fact that I previously received Treatment for Alcohol and/or Drug Abuse and information regarding Communicable Disease. I further understand that while my refusal to either sign this Authorization or authorize release of information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection-related testing, the fact that I previously-received treatment for Alcohol and/or Drug Abuse and information regarding Communicable Disease may adversely affect my potential or actual employment status, it will not adversely affect my ability to obtain other medically necessary care or treatment.

I understand that I may revoke this Authorization in writing at any time. Revocation will be effective when physically received by North Oaks Health System . I understand that any information previously authorized and actually released cannot be recovered by a written revocation of this Authorization. This Authorization shall automatically expire one (1) year after the date indicated below.

_____	_____	_____/_____/_____
Patient's Printed Name	Signature of Patient	Date
_____	_____	_____/_____/_____
Personal Representative Printed Name	Signature of Personal Representative	Date

Reason patient cannot sign: _____

Employee's Signature: _____