WORKPLACE
HEALTH SERVICES

Authorization for Release of Protected Health Information

Patient Name: _____

Address: _____

_____

Social Security Number: _____ Date of Birth: _____

I hereby authorize, direct, and consent to the release of my medical records by or to Methodist Occupational Health Centers, Inc. as follows:

TO BE RELEASED TO/FROM:

Name _____

Address _____

_____

_____

_____

☐ Insurance Carrier, Case Manager

☐ Employers

☐ Other Medical Provider

☐ Other - _____

_____

PURPOSE OF RELEASE:

☐ For Reimbursement and Medical Care

☐ Employer Requirements

DESCRIPTION OF THE INFORMATION TO BE RELEASED:

☐ All Medical Records including, but not limited to: Doctor Notes, X-ray reports, rehabilitation notes, drug test results, and specialty tests.

☐ Other _____

This authorization will also allow the issuance of verbal and written reports to the above named recipient.

I understand that I have the right to revoke this authorization at any time in writing, except to the extent that action has been taken in reliance thereon and that this consent will expire sixty (60) days from the date signed unless otherwise specified. I hereby recognize that the physician/patient privilege is waived, and direct that the requested information be given as authorized. I direct that a photocopy of this authorization shall be as valid as the original.
Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.
The expiration date of this authorization (consent) is 1 year from the date signed below. MOHCI and its affiliates cannot refuse treatment for not signing this authorization.

Date: _____ _____
(Patient)

Date: _____ _____
(Witness)

Privacy Notice Acknowledgement Statement

I acknowledge that I have received a copy of Methodist Occupational Health Centers, Inc and Affiliates Notice of Privacy Practices and understand that I may request a version of this privacy notice at any time.

_____ _____
Signature of Patient (Legal Guardian, if minor) Date