

Please fill out this form and give to your health care provider

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the release of my health information

FROM: Clinic/Provider: _____
Clinic Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

TO: Biosafety and Occupational Health Department
Thompson Center for Environmental Management
501 23rd Ave. SE
Minneapolis, MN 55455

I specifically authorize the release of the following information for occupational health requirements:

Immunizations/titers/boosters (list all): _____
Tuberculosis Screening, Exam, and/or Test
OSHA Respirator Protection Program Medical Evaluation, Exam, and/or Respirator Fit Test
OSHA Hearing Conservation Program Audiograms and/or audiometric data
Other: _____

PATIENT IDENTIFYING INFORMATION:

Name (please print): _____ Maiden/former/alias: _____
Birth date: _____ Student/Employee ID #: _____
Address: _____
Home phone: _____ Work Phone: _____

I understand that by signing this form, I am requesting that the health information specified be sent to the Biosafety and Occupational Health Department (BOHD) at the University of Minnesota. I understand that BOHD is not a health care provider.

I understand that I may revoke this authorization at any time by writing to the clinic or provider releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that this authorization will expire one year from the date of my signature or on the date or event I specify here, whichever is sooner (*entering date is optional*): _____

I understand that when this health information is released, it may no longer be protected by federal or state privacy laws and may be re-disclosed by the recipient.

Signature of Patient/Authorized Person
(If authorized person signing, also print name)

Authorized Person's authority to sign
(Parent, guardian, power of attorney, etc.)

Date

REASON PATIENT IS UNABLE TO SIGN: Minor Deceased Other: _____

Health Care Providers: Fax copies of records to (612) 626-9643 or e-mail a PDF version to uohs@umn.edu