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| Details of Candidate / Employee |
| Last Name:  |       | First Name: |       |
| Sex: | [ ]  Male [ ]  Female | Date (mm/dd/yyyy): |       |
| Job Title: |       | Street: |       |
| Department: |       | City: |       |
| Job Site Location: |       | State / ZIP Code: |       |

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| Records Released From |  | Records Released To |
| Name *(Medical Facility, Physician)*:      |  | Name *(Medical Rep, Physician, Self)*:      |
| Street:  |       |  | Street:  |       |
| City:  |       |  | City:  |       |
| State / ZIP Code:  |       |  | State / ZIP Code:  |       |
| Phone No.:  |       |  | Phone No.:  |       |
| Fax No.:  |       |  | Fax No.:  |       |

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| Purpose or Need for Disclosure |
| [ ]  | To evaluate my ability to perform essential job functions | [ ]  | Periodic review |
| [ ]  | To evaluate my ability to return to work | [ ]  | Further medical care |
| [ ]  | To evaluate whether any medical condition may pose a direct threat of harm to myself or others | [ ]  | For clearance to work in a high-risk or remote location |
| [ ]  | For other purposes (please describe):       |

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| Type of Information to be Disclosed |
| [ ]  | Medical examination reports:       to       |
| [ ]  | Other *(please specify)*:       |

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| [ ]  | I authorize release of my medical records in accordance with the specification listed above. I understand that my health information and medical records are confidential and cannot be disclosed without my written authorization, except where otherwise permitted by law. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).I understand that I have a right to inspect and receive a copy of the disclosed material. I understand that this authorization is voluntary and that I am under no obligation to sign this form. I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon the authorization. This authorization will continue until my termination of employment with the Company, unless I revoke the authorization prior to that time. I understand that the health information collected will be kept in a confidential file separate from my personnel file. |
| [ ]  | I do NOT authorize the release of my medical records. |

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| Employee Authorization |  | Witness |  |
| Name: |       |  | Name: |       |
| Signature: |  |  | Signature: |  |
| Date: |       |  | Date: |       |