Environmental Health & Safety

Medical Record Information Authorization Release Form

I, _____ , hereby authorize
(Full Name of Employee/Patient) (Please Print)

_____ , to release to
(Individual/Organization Holding Medical Records) (Please Print)

_____
(Individual/Organization Authorized to Receive Medical Information) (Please Print)

The following medical information from my personal medical records (describe generally the information desired to be released)

_____

_____

_____

_____

_____

I give my permission for this medical information to be used for the following purpose:

_____

_____

_____

_____

_____

but I do not give permission for any other use or re-disclosure of this information.

_____
(Full Name of Employee or Legal Representative) (Please Print)

_____
(Signature of Employee or Legal Representative)

_____
(Date of Signature)

Rev. 8/2022