Authorization for Intermountain WorkMed to Disclose Protected Health Information

Authorization to release the health information of:				
Name			Date of Birth	
This authorization is to release health information to:				
Company Name			Phone	
Address	City		State	Zip
The purpose of this disclosure is (check all that apply) ___Employers Request ___Employment related physical and/or work capacity determination ___Drug/Alcohol Testing				
Dates of service (today and other dates):				
Release the following information (check all that apply)				
___Physical examination & medical history, opinion of work capacity and applicable work restrictions	___Drug/Alcohol specimens and/or reports	___DOT Exam Information	___Medical treatment report including physical examination, medical history and work capacity.	
This authorization will remain in effect until ____ Unless otherwise noted above this authorization will remain in effect 180 days from the date signed (whichever is sooner)				

I understand that:

- Once Intermountain WorkMed discloses my health information by my request, it cannot guarantee that the company mentioned above will not re-disclose my health information to a third party. The company may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to Intermountain WorkMed to inspect and/or obtain a copy of my health information maintained at this facility.
- This authorization will remain in effect until the authorization expires as stated above, or until I provide a written notice of revocation to Intermountain WorkMed.
- I may refuse to sign this, but if I do, Intermountain WorkMed may not be able to provide the service, or Intermountain WorkMed may be required to report my refusal to my employer.
- I may change my mind in the future and ask Intermountain WorkMed not to send this information, if they have not already sent it; to do so I must provide a written request of revocation to Intermountain WorkMed. However, if I do, I may be required to pay for Intermountain WorkMed services, or, if this

service was provided as a condition of my employment, my employer may take action regarding my employment as a result.

Signature of Patient or Legal Representative ____ Date _______________

If signed by Legal Representative, Relationship to Patient ____