[WorkMed Horizontal no tag](http://intermountainhealthcare.org/services/medicalgroup/clinics/workmed/Pages/home.aspx)

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_