Occupational Medicine Associates

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Authorization to Disclose My Protected Health Information (PHI)

This form is for all record requests.

PATIENT INFORMATION

Patient's Full Legal Name:_____SS#:_____

Daytime Phone:_____ Date of Birth:_____

Maiden or other name used: _____

INFORMATION TO BE RELEASED FROM: OCCUPATIONAL MEDICINE ASSOCIATES

Covering the period(s) of care from: Date_____To_____

INFORMATION AUTHORIZED FOR DISCLOSURE (if included in my records):

Complete Health Record _____ L&I/Work Injury Documents _____ X-ray & diagnostic imaging reports _____
Visit/Discharge Summary _____ Clinical documentation of physical _____ Progress reports _____
Documentation of consultation _____ Immunization records _____ Photos, videos, digital or other images _____
Laboratory tests (please specify) _____

Sensitive Protected Health Information (please initial)
Behavioral health services/psychiatric care _____ HIV (AIDS virus)_____ Sexually transmitted diseases _____
Treatment for drug and/or alcohol use_____ Genetic counseling/testing _____ (Specify Other):_____

INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____
_____
_____

Phone: _____ Fax: _____

I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Occupational Medicine Associates, or
- Write a letter to Occupational Medicine Associates

This authorization will expire 90 days from the date signed and can be revoked at any time providing information requested has not yet been released. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing this authorization, I authorize OMA to disclose my protected health information

_____ _____

Patient Signature **Date**

_____

Office Use Only
Name/title of person releasing information: _____
Date:_____

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