

2012 Authorization To Discuss Pertinent Medical Information with the U.S. COAST GUARD

Complete all areas with a large **X**

Name **X** _____
 SS# **X** _____ DOB **X** _____
 Employer American Steamship/Liberty Steamship

I hereby authorize St. Luke's Occupational Health to release to, or discuss with, the US Coast Guard any pertinent information in his/her possession regarding any physical or medical condition that may require review by the Coast Guard prior to determining whether the Coast Guard should issue a credential(s) for maritime service.

I understand that this authorization is voluntary. I also understand that failure to provide authorization could affect the Coast Guard's ability to make a timely determination as to whether the Coast Guard should issue me a credential(s) for maritime service. This authorization will remain in effect until the Coast Guard determines whether to issue me the requested credential(s) for maritime service, but no longer than one year.

All information regarding mental health, chemical dependency, HIV, alcohol, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restriction action.		
<input type="checkbox"/> Mental Health	<input type="checkbox"/> HIV	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Alcohol Abuse	Initial to Exclude _____

- I understand this authorization will remain in effect for one (1) year from the date of signature, or until the following date or event: _____.
- I also understand this authorization may be revoked by me, in writing, at any time, but would not apply to any information already released in good faith. A request for revocation or questions about disclosures may be sent to the address listed above.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.
- I have read and understand the following statement about my rights.
- Upon request, I may see or copy information described in this release.
- I am not required to sign this release to receive my medical evaluation.

X _____ **X** _____
Signature of Patient or Authorized Representative **Date**

If Authorized Representative, relationship to patient is _____