

2012

AUTHORIZATION to RELEASE MEDICAL INFORMATION

*Complete all areas with a large **X***

Name **X** _____ SS# **X** _____ DOB **X** _____

Employer American Steamship/Liberty Steamship

Request release of information **FROM:**

To be released **TO:**

X Clinic Name	
X Address	
X City, State, Zip	
X Phone	X FAX

St. Luke's Occupational Health
 Attn: Deb Slater, Medical Records
 4702 Grand Av
 Duluth, MN 55807
FAX to 218-249-6828

Release the following information:

Reason for release: (Check all that apply)

2011-12 Merchant Marine Physical Exam & ALL Ancillary Testing
X DATE(S) of SERVICE _____

Employment (annual physical)
 Other:

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. **Please Exclude:**

Mental Health
 Chemical Dependency
 HIV
 Alcohol Abuse
 Sickle Cell Anemia
 Please Initial _____

- 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 authorizing disclosure of my medical information is voluntary; I can refuse to sign this authorization and still be assured treatment.
- I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

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

If Authorized Representative, relationship to patient is _____