Twin Rivers Urgent Care

AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

TEST SUBJECT NAME	BIRTH DATE	SOCIAL SECURITY NO.
X	X	X
Test Subject Address		**Test Subject Telephone**
X		X

X I HEREBY AUTHORIZE PROVIDER TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED TEST SUBJECT FOR RESEARCH AND PUBLICATION PURPOSES CONDUCTED BY DR. GARY HARBIN AND RESEARCHERS AT OCCUPATIONAL PERFORMANCE CORPORATION.

X I HEREBY AUTHORIZE TWIN RIVERS URGENT CARE TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED TEST SUBJECT TO: (name of employer) _____

and my employer's officers, agents, supervisors, and health care providers involved in my employment.

X For Test date(s):_____

Specify date(s) - this line MUST BE completed

For the following purposes(s) **At the request of test subject and for all purposes connected with the employment relationship**

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED
(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)

X	Entire Record	☐	Test subject Demographic Information
X	Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records.	☐	Test subject Medical History
		☐	Results of Physical Capacity Profile® Exams
		☐	Physical Capacity Profile® Notes
☐	Other_____		

This authorization shall be effective immediately from my signature and has no expiration date.

I understand that the records to be used or disclosed pursuant to this authorization may contain information that is subject to special protections pursuant to 42 C.F.R. 164.508 and some state laws. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

☐ Records relating to participation in any federally assisted drug and alcohol abuse program

☐ Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition

☐ Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the designated privacy officer of the provider to whom this authorization is sent. (Note: Revocation is not effective for disclosures that have already been made)

X _____ X _____

Date *Signature of **Test subject** or Authorized Agent/Representative*

X _____ _____

*Printed Name of **Test subject** or Authorized Agent/Representative* *Authorized Agent/Representative's Relationship to Test subject*

_____ _____

Address of Authorized Agent/Representative *Telephone # of Authorized Agent/Representative*

_____ _____

Date *Signature of Witness*