AUTHORIZATION FOR RELEASE OF INFORMATION
TO BE COMPLETED BY COVERED PERSONS WHO SUBMIT A
MEDICATION DISCLOSURE FORM

To: **Custodian of Records**

I hereby authorize the use or disclosure of my health information as described below.

Name: ______________________________

Last four digits of SSN: ______________________________

Date of Birth: ______________________________

Persons authorized to provide information: Any HIPAA-covered entity including, but not limited to, any doctor, hospital, pharmacy, or other medical service provider, health plan, health maintenance organization, or insurer.

Persons authorized to receive information: Company's Management, Human Resources, or Owner.

Specific description of information (including date(s) of service): Regarding the Medications Disclosure Form for Safety-Sensitive Positions that I completed for my work with Company, I hereby authorize and request you to permit Company's Management, Human Resources, or Owner to examine any and all information, documents, files, records, charts, progress notes, diagnoses, and the like, in your possession, custody, or control, concerning your care, evaluation, treatment, and billing pertaining to me, including, but not limited to, any and all information concerning matters of a physical, mental, emotional, psychological, and psychiatric nature, but shall exclude any or all psychotherapy notes kept and maintained separately from other medical records. I further authorize and request you to permit said representative to copy or reproduce the desired portions of your documents, files, records, charts, progress notes, evaluations, and the like pertaining to such care, evaluation, treatment, and billing. Records obtained pursuant to this authorization will be used for purposes of determining my ability to undertake safety-sensitive work for Company only.

I understand that I have the right to examine any mental health records that are disclosed pursuant to this authorization at any time upon request to Company.

A photocopy of this authorization is to be treated as an original.

Purpose of the use or disclosure: Determining the ability to undertake safety-sensitive work for Company.

I understand that I am entitled to a copy of this form when I sign it. Initials: ________

THIS DOCUMENT DOES NOT CREATE A CONTRACT OF EMPLOYMENT

I understand that this authorization will expire thirty (30) days from the date it is signed below.

I understand that I have the right to revoke this authorization at any time by notifying any covered entity in writing. The revocation will be effective only from the date it is received, will not apply retroactively, and will not be effective to the extent the covered entity has already relied on this authorization.

I understand that this authorization is voluntary and that the plan or service provider will not condition treatment or other services, enrollment in a group health plan, eligibility for benefits, or payment of claims on giving this authorization.

I understand this authorization may allow the information specified herein to be disclosed to persons or organizations that are not health plans, covered healthcare providers, or healthcare clearinghouses subject to federal privacy laws governing health information. I understand that the information authorized to be disclosed pursuant to this authorization may be subject to further disclosure by the recipient(s) and is no longer protected by federal privacy regulations.

By signing this form, I authorize the disclosure of the information specified to the person or persons identified above.

____ ____________________________
Signature of Individual or Legal Representative Date

Printed Name of Legal Representative: ____

Relationship to Individual: ____