

RELEASE OF INFORMATION

At my request permission is hereby given to Occupational and Environmental Medicine to:

- release the following information to UNIVERSITY HEALTH SERVICE – BARBARA TRIPP
 - all medical records on file
 - medical records related to claim or current examination
 - diagnostic reports related to claim or current examination
 - all diagnostic reports on file
 - progress reports
 - immunization records
 - other _____

- receive the following information from UNIVERSITY HEALTH SERVICES
 - all medical records on file
 - medical records related to claim or current examination
 - diagnostic reports related to claim or current examination
 - all diagnostic reports on file
 - progress reports
 - immunization records
 - other _____

Regarding the following individual:

Name: _____
 Social security number: _____
 Date of birth (mm/dd/yr): _____
 Daytime Phone Number: _____

I understand that I may withdraw my consent in writing at any time except where a disclosure has already been made in reliance on my prior authorization. I also understand that privacy rules do not protect against redisclosure of this information. If access is denied pursuant to New York State Public Health Law, I will be so notified and provided information on the appeal process. Any pre-paid fee will be refunded.

I understand this consent will remain in effect:

- For the duration of this claim under workers' compensation or disability
- For the duration of my employment at the University of Rochester
- For a duration not to exceed 5 years from the date of signature.

Patient / client signature: _____ Date: _____

If a minor or otherwise not capable of informed consent:

I _____ being the Parent ___ Legal Guardian ___ Other ___ of the above named individual, have reviewed the above information and agree to the release of information as delineated above.

Signature: _____ Date: _____ COPY OFFERED: ___ Accepted ___ Denied