**Complete and Return this form to:**

**Eastern Virginia Medical School**

**Occupational Health**

**P.O. Box 1980**

**Norfolk, VA 23501-1980**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (print full name) hereby authorize Eastern Virginia Medical School (EVMS), Department of Occupational Health to disclose to (individual or organization that you want to receive your medical information) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the following medical information from my EVMS Occupational Health record (check all that apply):

🞎 Immunizations Given 🞎 Chest X-ray results

🞎 TB skin tests and results 🞎 TB prophylaxis records

🞎 Laboratory Test Results

🞎 Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my permission for this medical information to be used only for the following purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This Authorization shall be valid (check only one):

🞎 Indefinitely 🞎 until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that:

Once disclosed, your medical information may be re-disclosed by the recipient individual or organization and may no longer be protected by law.

You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that EVMS has already disclosed information based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

I authorize EVMS to disclose my medical information as indicated above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature. I am the (check only one): Date

🞎 Individual named above; or

🞎 Personal representative of the person named above. Complete the following and attach appropriate documentation (i.e. Power of Attorney):

Name:

Address:

Phone:

Relationship or Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_