Employer Medical Information Release Authorization Form

Instructions: Please complete all sections of this authorization form to allow the release of your medical information to your employer. This form is designed to be printed and filled out.

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1. Employee Information

Full Name: _____

Date of Birth: _____ (MM/DD/YYYY)

Employee ID / Social Security Number (Last 4 digits): _____

Phone Number: _____

Email Address: _____

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2. Authorized Healthcare Provider / Entity

I hereby authorize the following medical provider, clinic, or hospital to release my medical records:

Provider/Facility Name: _____

Address: _____

Phone Number: _____

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3. Recipient Information (Employer)

The authorized medical information should be released to:

Employer Name: _____

Representative/Department: _____

Address: _____

Fax Number (for sending records): _____

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4. Scope of Information to Be Released

Please specify the medical information you authorize to be released (Type "YES" in the box next to all that apply):

_____ All medical records regarding the recent injury or illness

_____ Family and Medical Leave Act (FMLA) documentation

_____ Workers' Compensation claim records

_____ Drug and alcohol test results

_____ Return-to-work / Fitness-for-duty evaluations

_____ Other (Please specify): _____

5. Purpose of Disclosure

The sole purpose of this disclosure is (Type "YES" next to the primary reason):

[ ] Processing of FMLA or short-term/long-term disability claims

[ ] Evaluation of Workers' Compensation injury claim

[ ] Determining reasonable job accommodation under the ADA

[ ] Verification of fitness for duty to return to work

6. Term and Expiration of Authorization

This authorization will automatically expire on the date or event specified below:

Expiration Date: [ ] (MM/DD/YYYY)

Expiration Event (if applicable): [ ]

7. Authorization and Signature

By signing below, I acknowledge that I have read and understand this authorization. I authorize the release of my medical records as described above. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Employee Signature (Sign after printing): _____

Date of Signature: [ ] (MM/DD/YYYY)