

**AUTHORIZATION FOR USE AND OR/DISCLOSURE OF  
PATIENT HEALTH INFORMATION  
A HIPAA COMPLIANT RELEASE**

*These forms are in compliance with the HIPAA (Health Insurance Portability and Accountability Act)*

The following forms will allow the organization to obtain copies of medical records and other pertinent documentation relating to Fitness-for-Duty evaluations.

**Authorization for Use and/or Disclosure of Patient Health  
Information**

**A HIPAA Compliant Release**

I hereby authorize:

\_\_\_\_\_  
(Name of Provider)

To Disclose to: (enter name of Fitness-for-Duty medical provider below)

\_\_\_\_\_  
Records and information pertaining to:

\_\_\_\_\_  
(Patient Name)

**Duration:** This authorization shall become effective immediately and shall remain in effect for ninety (90) days from the date of signature.

I acknowledge my right to receive a copy of this signed authorization. Copies of this signed authorization will be considered as valid as the Original.

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524

**Re-disclosure:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**Revocation:** This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Records to be Released:**

**Medical Records-** Specify by body part, treating physician or treatment dates pertinent to the fitness-for-duty evaluation.

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**Psychiatric Information**

\_\_\_\_\_  
(Signature) (Date)

**Drug \ Alcohol Information**

\_\_\_\_\_  
(Signature) (Date)

**Other Information** (Specified below)

**Specifying the other records to be disclosed:**

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The requestor may use the information authorized on this form for the following purpose only: **To review records in reference for a Fitness-for-Duty evaluation.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Patient Name