



**Request for Employee Health Record Information
and Authorization to Release Information (please print)
Fax back to (509) 942-2731**

Name: _____ Date of Birth: _____

Current Employee (yes/no): _____ If no, Term. Date: _____

Phone Number: _____

I hereby request Kadlec Medical Center to obtain a copy of my individually identifiable health information as described below. I understand that this authorization is voluntary. Furthermore, I attest that:

1) I am a current Kadlec Medical Center employee; OR my employment ended in 2012; OR my employment ended in 2013. _____ Initial

2) I am a former Kadlec Employee and my termination date was prior to 2012. I understand that my employee health information is not kept onsite at Kadlec and that it may take up to a month to locate my individual health file from the storage location. Furthermore, I understand if my individual health file is not onsite, that I may be responsible for a \$45.00 charge to obtain a copy of any available employee health information from my individual identifiable health file. _____ Initial

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Description of information to be released: (circle all that apply)

TB test Results Chest X-Ray reports Immunizations/Titers Other: _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to: Employee Hospital Physician Other

Name Address City State Zip

Fax Number: _____ (Please initial to verify)

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Employee Health Services at the above address in writing. I also understand that the written revocation must be signed and dated with the date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Employee

Date of Authorization

