*Not to be used for workers' compensation

Atrium Health

Patient Name: _____
Address: _____
Phone Number: _____ Date of Birth: _____ Medical Record Number: _____

CONDITIONAL AUTHORIZATION TO RELEASE INFORMATION FOR HEALTH CLEARANCE (OCCUPATIONAL MEDICINE)*

By signing below, you authorize Atrium Health, including its urgent care, occupational medicine, and employer site locations (collectively, "Atrium"), to use and disclose your relevant physical and mental health information from your entire medical record (including physicals, medical clearance forms, lab test results, alcohol and drug screenings, diagnoses, evaluations, and medical history) that our providers determine is necessary to complete or respond to any forms, requests, and clarifications related to your employment screenings and clearance for prospective or current jobs, including health certificates and job performance clearance forms, such as those from the Department of Transportation, and any similar forms provided by you, a government agency, or your potential/current employer or their agents, administrators, or contractors ("Representatives").*

**Employee/Patient is responsible for providing us with the forms and with any relevant job description or duties, upon which we are reasonable to rely. We are authorized to complete all fields on the forms provided to us.*

You authorize us to directly provide the information verbally or in writing, by mail, fax, phone, email, or e-submission to:

- Company/Agency (including its Representatives): _____
- Contact Name/Department: _____ (if blank, release will be as directed on form)
- Address: _____
- Phone: _____ Fax: _____ Email: _____

**We will rely on contact addresses and numbers provided by the employee/patient or the employer/agency as accurate and authorized.*

We are making these disclosures and providing the above information at your request and for purposes of your prospective or current employment, or clearance to perform job duties. **This Authorization will expire one (1) year from the date signed below.** In addition, note that:

- You have the right to revoke this Authorization by contacting the releasing location in writing. The revocation will not apply to information that was disclosed under this Authorization before it was revoked.
- This release includes information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
- Information that is used or disclosed under this Authorization may be redisclosed by the recipient and may no longer be protected by state and federal privacy laws.
- Because the only reason for your treatment is to create information to be shared with your employer, such as for a pre-employment screening or a health clearance exam, we will not treat you unless you sign this Authorization.
- Atrium will not share or use your health information without your permission other than by ways listed in Atrium's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
- A fee may be charged for providing the protected health information.

By signing this Authorization, I acknowledge that I have read and understand this Authorization and agree to its terms.

Patient Signature: _____ **Date**: _____