Penn Medicine
Chester County Hospital

The Occupational Health Center & Travel Medicine Program

Authorization for the Use/Disclosure of Protected Health Information

______________________________ ______________________
Print Patient Name Date of Birth

I authorize **The Occupational Health Center** to use/disclose my protected health information ☐ **to:** / ☐ **from:**

Name: ______________________________ **Fax:** ______________

Address: ____

City: ______________________ **State:** ________ **Zip:** __________

The protected health information to be used or disclosed is as follows:
(Please check off all that apply or record other information in the space provided.)

☐ Entire Medical Record
☐ Medication List
☐ Laboratory results from ______________ to ______________.
Date Date
☐ X-ray or other imaging reports from ______________ to ______________.
Date Date
☐ Office Notes from ______________to ______________.
Date Date
☐ Other information (please describe):______________________________
____

This information is being disclosed for the following purpose: At my request ☐
____
____

I understand that I have the right to revoke this authorization, in writing, at any time. This authorization will automatically expire in twelve (12) months unless otherwise revoked or indicated to expire on ___________.
If your medical record contains any of the following information and you wish us to release it, please indicate by placing your initials next to each type of information:
☐HIV/AIDS _____ ☐Mental Health Treatment _____ ☐Drug/Alcohol Treatment _____
I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

______________________________ ______________________
Signature of Patient Date

Office Use Only
Records, as requested above: ❑Mailed
❑Faxed to______________________
❑Given to Patient
Date: ____________________ By: ______________________________