UNIVERSITY OF MINNESOTA

Biosafety and Occupational Health Department *501 23rd Ave. SE*
Office: (612) 626-5008
Fax: (612) 626-9643
Email: uohs@umn.edu
https://.bohd.umn.edu

Please fill out this form and give to your health care provider

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the release of my health information

FROM:

Clinic/Provider:_____

Clinic Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

TO:

Biosafety and Occupational Health Department
Thompson Center for Environmental Management
501 23rd Ave. SE
Minneapolis, MN 55455

I specifically authorize the release of the following information for occupational health requirements:

- ☐ Immunizations/titers/boosters (list all):_____
- ☐ Tuberculosis Screening, Exam, and/or Test
- ☐ OSHA Respirator Protection Program Medical Evaluation, Exam, and/or Respirator Fit Test
- ☐ OSHA Hearing Conservation Program Audiograms and/or audiometric data
- ☐ Other:_____

PATIENT IDENTIFYING INFORMATION:

Name (please print):_____ Maiden/former/alias: _____

Birth date:_____ Student/Employee ID #:_____

Address:_____

Home phone:_____ Work Phone:_____

- ☐ I understand that by signing this form, I am requesting that the health information specified be sent to the Biosafety and Occupational Health Department (BOHD) at the University of Minnesota. I understand that BOHD is not a health care provider.
- ☐ I understand that I may revoke this authorization at any time by writing to the clinic or provider releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- ☐ I understand that this authorization will expire one year from the date of my signature or on the date or event I specify here, whichever is sooner (*entering date is optional*):_____
- ☐ I understand that when this health information is released, it may no longer be protected by federal or state privacy laws and may be re-disclosed by the recipient.

Signature of Patient/Authorized Person *(If authorized person signing, also print name)*	Authorized Person's authority to sign *(Parent, guardian, power of attorney, etc.)*	Date

REASON PATIENT IS UNABLE TO SIGN: ☐ Minor ☐ Deceased ☐ Other:_____

Health Care Providers: Fax copies of records to (612) 626-9643 or e-mail a PDF version to uohs@umn.edu