Advocate Health Care | Aurora Health Care

Now part of ADVOCATEHEALTH

Patient Label Box

Occupational Health

(1) PATIENT INFORMATION:

Name | Address | City | State | Zip

Date of Birth | Area Code/Telephone Number | Previous Name(s)

(2) Persons/Organizations Authorized to *Disclose* Patient's Health Information:

Name

Street Address

City, State, Zip Code

(3) Persons/Organizations Authorized to Receive Patient's Health Information: ☐ Self; or

Name

Street Address

City, State, Zip Code

(4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ (month/year) to _____ (month/year) **If left blank, only information from the past two (2) years will be disclosed.**

(5) Health Information to be Disclosed:

☐ Client Service Abstract ☐ Other _____

☐ Check here if you do not want Human Immunodeficiency Virus (HIV) test results &/or AIDS/AIDS-related illness disclosed

(6) PURPOSE: ☐ Employment Requirements ☐ Other _____

(7) EXPIRATION: This Authorization is good for: ☐ 1 month ☐ 6 months ☐ 1 year Other date or event _____

If no date or event is specified, this Authorization will expire one (1) year from the date signed. **IL Only:** Mental health/ developmental disability records/information may be released only on the day the authorization is received.

(8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION I have the right to inspect and receive a copy of the health information I have authorized to be disclosed by this Authorization. I understand that I may be charged a fee for record copies. I understand that I am aware that I may revoke this Authorization by notifying the health information department in writing. I understand that my revocation will not be effective as to uses and/or disclosures already made in reliance upon this Authorization. I realize that the information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law. I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Advocate Aurora Health, Inc. ("AAH"). I understand that this is an evaluation and that my participation does not imply a Doctor/Patient relationship with the examining medical provider. I also understand that the occupational health services received from AAH are provided for the purpose of disclosing some or all of the results to my employer or other third party. Refusal to sign this Authorization may result in a refusal by AAH to provide me with the specific occupational health services that have been requested.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____ **DATE:** _____

If another person is signing other than the patient, please list the relationship of the person to the patient. _____

(9) In the event additional information is needed, I further authorize AAH to access my general health records and my other health care providers' treatment information for assessment and employment requirements. I am aware that any information created, collected, and/or maintained by AAH and its affiliated hospitals, clinics, labs, pharmacies, etc. may be included in my AAH record. Further, I understand that my AAH record and other health care providers' records may include, if applicable, HIV/AIDS test results, behavioral health records, substance use disorder records. I am aware AAH will have access to all existing information in my records and future information not yet created until the expiration date of this Authorization.

Signature of Patient/Legal Representative | Date

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PATIENT AUTHORIZATION REFERENCE GUIDE

Health Information to be Disclosed to your Employer may include the following:

CLIENT SERVICE ABSTRACT may include records related to the following, if these services were provided by Advocate Aurora Health Occupational Health:

- Progress notes, medical history, consultations, radiology reports, EKG, pathology reports, procedure reports, medication list, therapy evaluations and notes
- Results of physicals, and any information provided in conjunction with a physical
- Drug tests
- Breath, blood, saliva, or urine alcohol tests
- Spirometry tests
- Respiratory fitness tests
- Immunizations and vaccinations; may include previous immunizations records from Immunization Registry or supplied by the patient
- Audiometric tests
- Lab results may include lab results supplied by the patient
- Other screenings performed for the purpose of determining employment or related to workplace Surveillance