Meritas Health Occupational Medicine
Authorization for Use and Disclosure of Patient Health Information

Patient Information:
Patient Name:
Date of Birth:
SSN:
Address:
Telephone:

The following individual/entity is authorized to make the disclosure described in this form:
Meritas Health Occupational Medicine 2700 Clay Edwards Drive,Ste.120 North Kansas City, MO 64116

The information to be disclosed is:
Except as noted below, all information relating to my work-related injury or illness which occurred on the following date:

Check below if you do **NOT** want any of the following information disclosed:
○ relating to care and treatment for mental health conditions ○ relating to care and treatment for drug and alcohol abuse ○ relating to HIV testing, infection status, or care and treatment for HIV/AIDS ○ relating to genetic testing

The purpose of the disclosure is:
Evaluation and coordination of care for my work-related injury or illness.

The information is to be disclosed to (list name):
My Employer:
My Workers' Compensation Insurer:
Other (example, third-party administrator):

Expiration: This authorization expires upon the following date or event: _____. If left blank, I agree that this authorization shall be valid for a period of six (6) months from today's date.
Revocation: I understand that I have the right to revoke this Authorization at any time, except to the extent that the Clinic has already taken action in reliance of this Authorization. I may revoke this Authorization by submitting my revocation in writing to the Provider at the address stated above.
Redisclosure: I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be subject to protection under the Provider's policies and procedures or federal laws protecting the privacy of patients' health information.
Voluntary: I understand that the Provider does not condition the patient's treatment on my execution of this Authorization and that I may refuse to sign this Authorization. However, if the Provider is providing health care treatment to the patient solely for the purpose of creating health information for disclosure to the person or entity named above, if I refuse to sign this authorization, the Provider may not provide such health care treatment to the patient.

_____ _____
Signature of Patient/Parent/Guardian/Legal Representative Date

_____ _____
Printed Name of Patient Representative Relationship to Patient