

AUTHORIZATION FOR THE USE AND DISCLOSURE OF

EMPLOYEE HEALTH INFORMATION

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| **Employee Name** | **Date of Birth** | **Social Security Number** |
| **Address** | | |

I hereby authorize Erie County Medical Center Corporation (ECMCC) Team Mate Health to use or disclose

my health information as described below. I understand that this authorization is voluntary and I may

refuse to sign it. I understand that the information used or disclosed pursuant to this authorization

may be subject to re-disclosure by the recipient and no longer protected by ECMCC.

* **Right to Revoke:** I **u**nderstand that I may revoke this authorization at any time by providing written notice to ECMCC Team Mate Health.

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| 1. Name and Address of Provider or Entity to Release this Information;   **Employee Health/Center for Occupational & Environmental Medicine - Erie County Medical Center Corporation/Terrace View 462 Grider St., Buffalo NY 14215** |
| 1. Name and Address of Person(s) to Whom this Information Will Be Disclosed:   Please initial here \_\_\_\_\_\_ and provide email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to request that records be sent via email. Please note that by initialing above, you are consenting to receive records via an unsecure (meaning non-encrypted) email. |
| 1. Purpose for Release of Information: |
| 1. Specific information to be released:  * Medical Record from (insert date) to (insert date) * Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.   **□** Other: \_ Include: *(Indicate by Initialing*) Alcohol/Drug Treatment  \*Mental Health Information  \_ HIV-Related Information  Disclosure of alcohol and drug abuse information is controlled by federal law, 42 C.F.R. Part 2. RECIPIENTS: please note that re-disclosure of either type of information is prohibited without additional written authorization unless otherwise permitted by state or federal law.) |
| 1. This consent shall expire six (6) months from its signing, unless a different time period, event or condition date is specified here: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of Employee Date

**Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the employee.

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Signature of witness Date

\*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.