

**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:**

University Health and Safety - Occupational Health  
Thompson Center for Environmental Management  
501 23<sup>rd</sup> Ave. SE  
Minneapolis, MN 55455  
Phone: (612) 626-5008 Fax: (612) 626-9643

I specifically authorize the release of the following information: \_\_\_\_\_

***IMMUNIZATION RECORDS ONLY***

Reason for release of information: *Biosafety and Occupational Health Dept. (BOHD) Requirements*

**PATIENT IDENTIFYING INFORMATION**

Name (please print): \_\_\_\_\_ Maiden/former/alias: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Student/Employee ID #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home telephone: ( ) \_\_\_\_\_ Work telephone: ( ) \_\_\_\_\_

- 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/event I **specify here, whichever is earlier:** \_\_\_\_\_  
*Specify expiration date/event (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 \_\_\_\_\_

**Patients: please fill out this form and return to your health care provider**  
**Health Care Providers: Please Fax Copies of Records to (612) 626-9643**