

Authorization to Disclose Confidential Medical Information

I authorize:

DR. _____

ADDRESS _____

CITY/STATE/ZIP CODE _____

PHONE NUMBER _____

to disclose complete information to the University of Alabama at Birmingham Hospital Employee Health Services Office related to my medical case history, examinations and treatment that I have received while under his/her care.

I also authorize Dr. _____ to discuss my medical case history with an authorized representative of the UAB HR Relations Office in order for that office to assess the need for a reasonable workplace accommodation if necessary.

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PATIENT’S NAME _____

PATIENT’S SIGNATURE _____

SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____

STREET ADDRESS _____

CITY/STATE/ZIP CODE _____

DATE _____