

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