OCCUPATIONAL MEDICAL SERVICES

Your Partner in Employee Health

DOT Physicals

Exposure Treatment

Vaccinations

Drug Testing

Onsite Services

Workers' Comp Injury Care

Training Programs

Audiometry

Spirometry

Blood Work

Respiratory Certification

Physical Therapy

Radiology

Medical Review & Random Pull Programs

Visit us online at www.omsmd.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO:
OCCUPATIONAL MEDICAL SERVICES

Patient Name: _____ DOB: ____/____/____

Previous/Other Name: _____

This will authorize: _____

_____

_____

To Release to: Occupational Medical Services

_____

_____

P: _____

F: _____

General Information Requested

Medical Information Requested:

- □ Complete Records
- □ Lab
- □ X-Ray Reports
- □ Immunization
- □ Other
- □ I am moving (New Address):

_____

Reason For Release:

- □ To update regular doctor (Primary)
- □ I have been referred to another doctor
- □ I want/ need a second opinion
- □ I am changing doctor (provider)
- □ Dissatisfaction with care

This consent may be revoked at any time by notifying the above name provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

Restrictions:
The authorization is being given with the understanding that the reviewer may not further use or disclose the medical information unless another authorization is obtained from the patient or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient: _____ Date: _____