BAPTIST HEALTH®

AUTHORIZATION FOR RELEASE OF RECORDS TO EMPLOYEE HEALTH SERVICES

Patient's Full Legal Name (last/First): _____

Date of Birth: _____ Last four digits of Social Security # _____ Telephone: _____

Address: _____

Please check where the services were provided: □ Baptist Physician Office Provider _____ Address _____

□ Baptist Hospital (specify location) _____ □ Baptist Health Deaconess Madisonville

□ Baptist Health Deaconess Madisonville Medical Group Provider _____ Address _____

□ I authorize BAPTIST HEALTH SYSTEM - Employee Health to use and obtain my health information to process workers compensation claim and/or to follow up on a workplace incident or exposure.

The purpose of the requested use or disclosure is: ☐ At the request of the individual ☐ Worker's Compensation ☐ Evaluation or treatment of exposure to an infectious disease ☐ Other (please specify): _____

The requested information to be used or disclosed includes the following specified Medical Record information during the approximate time period from (Date) _____ to (Date) _____ (including information related to my identity, diagnosis, prognosis and/or treatment).

Please check appropriate items:

- ☐ TB Test Result
- ☐ Influenza vaccination or diagnostic testing
- ☐ MMR and/or Rubeola/Rubella/Mumps Vaccine or Titer
- ☐ Hepatitis B Vaccine or Titer
- ☐ HIV/AIDS Testing
- ☐ COVID Vaccination or diagnostic testing
- ☐ Other(specify): _____
- ☐ Chest X-ray and/or other diagnostic imaging
- ☐ Tetanus (Tdap) Booster or Pertussis diagnostic testing
- ☐ Varicella (Chicken Pox) Vaccine or Titer
- ☐ Hepatitis C Titer
- ☐ OSHA Medical Clearance or Fit Test
- ☐ Telehealth or Urgent Care, Occupational Medicine, Emergency Dept. visit for workplace exposure or injury

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exceptions: _____

Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. However, the recipient may be prohibited from disclosing any substance abuse information under the federal confidentiality requirements for alcohol and drug abuse patient records and the Public Health Service Act. Such information may not be used to criminally investigate or prosecute any alcohol or drug patient. Further, state law prohibits a recipient from making any further disclosure of test results relating to HIV or AIDS without the specific written consent of the person to whom such information pertains. A general authorization for the release of medical or other information is NOT sufficient for such purpose.

This authorization will expire upon the occurrence of the following event or condition: _____ . If no event or condition is listed,it will expire in 180 days. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the Hospital's Health Information Management Department. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure healthcare treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form, after signing it.

_____

Signature of Patient/Authorized Representative (include relationship or nature of authority)

___)___)_____

Date

Please email completed form to: BHSEmployeehealthROI@bhsi.com