Workplace Health Services
A Service of Wyoming County Community Heath Systems
400 N. Main Street Warsaw, New York 14569
(585) 786-8940, ext. 4549 FAX: (585) 786-1269

Name:_____ Former/Maiden Name:_____

Current Address:_____

Birth Date:___/_____/_____ Telephone (home):_____ (Work):_____

I Authorize Information Released From: **Please Release My Records To:**

_____ _____
Name of Facility Name of Requester

_____ _____
Address Address

_____ _____
City, State, Zip City, State, Zip

Purpose of Release: (please check box)

Medical Comp Legal Self/Other_____

Type of Information to be released

Immunization Records ف Pre-placement Physical ف All
Confidential Employee Incident Report (CEIR): Date of CEIR requested _____

PERMISSION TO FAX INFORMATION YES NO
I specifically consent to the faxing of my employee records. All faxed material will contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot always be guaranteed.

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law.

BY INITIALING: I authorize the release of the following protected or sensitive information:
_____Mental Health Records _____AIDS/HIV Information (State law requires separate consent-attached) ____Drug Screen

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.
If I fail to specify an expiration date, event or condition, THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE OF SIGNING.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and no longer protected by Federal privacy regulations.

** I understand that I need not sign this form in order to ensure healthcare treatment, payment, enrollment in my health plans, or eligibility for benefits.

I hereby release Wyoming County Community Hospital from any liability and responsibility resulting from said Hospital's furnishing such report to the above named party and hold said Hospital harmless in any and all claims, suits or other forms of physical examination or in response to my above mentioned request.

_____ _____
Signature Relationship Date Witness Signature/Date ف ID verified if applies