



Public Safety Health and Wellness

Specializing in the Health Care of Firefighters, EMS and Police Personnel

Authorization for Release of Health Information

By signing below, I hereby authorize Public Safety Health and Wellness to release health information to: _____.

This authorization includes use and disclosure of all health information obtained by Public Safety Health and Wellness, which includes but is not limited to: drug and alcohol test, health and physical information, EKG test, Stress Test, Chest X-ray results, blood and urine lab results, Pulmonary Function Test and Fit Test results.

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if:

Public Safety Health and Wellness, has to take action in reliance upon this Authorization;

Or, if this Authorization was given as a condition of obtaining Insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy.

This Authorization shall expire 360 days after the date of this authorization.

I understand that I may revoke this Authorization by written revocation at any time.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

(Signature)

(Date)

(Print Name)

Test results requested: _____

Please send test results to the following:

Name: _____

Address: _____

Email: _____

Fax Number: _____

Fax back to us at 937-743-9475

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