



**AUTHORIZATION TO RELEASE MEDICAL RECORDS FOR
OCCUPATIONAL HEALTH SERVICES
(Vaccinations, Titer Results, & Pre-physicals only)**

This Authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize Tualatin Valley Fire & Rescue to release a copy of the medical record obtained and/or recorded by their employees to the person identified below. I specifically authorize the release of immunizations and testing information as a part of the medical record.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

Patient Name: (print) _____

Agency: _____

Patient Date of Birth: ____/____/____ Social Security No. (last six digits) _____

Purpose of Request: _____

* * * * *

Please release to: (Print) _____

Phone: _____

Please release records by: (Check One)

Fax: _____

Mail: _____

This Authorization may be revoked at any time. To revoke this Authorization, I understand that I must do so by written request to the Tualatin Valley Fire & Rescue Occupational Health Services Records Custodian at the address below. The only exception is when action has been taken in reliance on the Authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

Date

Signature of Patient or Other Person
Authorized to Sign for Patient

Relationship to Patient

Printed Name