# Authorization for Release of Information

I (print name clearly)_____
First Last

Date of Birth: _____/_____/_____ Phone/Cell#: _____

I, hereby give my consent to Occupational Health Services at Stanford Health Care and Stanford Children's Health to release the following medical surveillance information. (Please check all that apply)

- ☐ All vaccinations and titers as they relate to hospital medical surveillance
- ☐ All tuberculosis screening examinations including blood tests, skin tests and x-rays.
- ☐ Tuberculosis screening questionnaire (the last one completed)
- ☐ N95 Fit testing results.

I understand I have the right to receive a copy of this Authorization and any photocopy or facsimile of this authorization shall be considered as the original.

Please send my information to the following person/organization:

_____

By the following method of delivery:

- ☐ Fax to the following number: _____
- ☐ E-mail (SHC/LPCH addresses only)
  SHC/LPCH e-mail address: _____
  Rewrite SHC/LPCH e-mail address: _____
- ☐ Send via home mailing address:_____

I understand that I may revoke this authorization at any time in writing if signed by me and delivered to Audrey Sadler, Occupational Health at SHC MC 5205.

Signature _____ _____
Employee's name Date

**FAX THIS FORM TO (650) 618-8661 or email**
**OHSmedicalrecords@stanfordhealthcare.org**

**Due to high volume of requests. Please allow 7-10 working days!!**