Employee Health Services
Authorization for Release of Health Information

Please Print Legibly

Date: Employee # (*if applicable*): Date of Birth: / /

Street Address: City:

State: Zip Code: Email Address:

Home #: Cell #: Work #:

I, ____, hereby authorize Northwell Health Employee Health Services to release my specified information below:
(*print name*)

Print Previous Name (if applicable), ____

Please put an "X" next to the document(s) requested*:* (please note that you will only receive the most current information unless otherwise specified):

- ☐ History and Physical Examination
- ☐ X-Ray Results
- ☐ Laboratory Tests
- ☐ Urine Drug Screen
- ☐ Tuberculosis Screening Tests (TST/PPD)
- ☐ Immunization Records
- ☐ Other (please specify):____

Please put an "X" next to your current status:

- ☐ Employee
- ☐ Licensed Independent Practitioner
- ☐ Volunteer
- ☐ Other (specify):____
- ☐ Termed Date (if applicable) ___/___/___

Please note that the processing of medical records may take up to 7 business days from time of receipt.

Please put an "X" next to the delivery method:

- ☐ Pick Up - You will receive a telephone call when medical record is available. If not picked up within 7 days from call, record will be mailed
- ☐ Emailed – Applies ONLY to Active Employees with a Northwell Health email address
- ☐ Mailed – Anticipated delivery time of 10 to 14 days

If the option "Pick Up" or "Mailed" is chosen, an address that the records may be sent to **Must** be provided in the address field above.

This authorization is effective until requested documents have been released.

By signing this authorization form, you authorize the disclosure of your health information as described above. This information may be redisclosed if the recipient described on this form is not required by law to protect the privacy of the information.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to Employee Health Services, Northwell Health, 410 Lakeville Road, Ste 206, New Hyde Park, NY 11042.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative (parent, guardian or individual authorized to consent to the use or disclosure of information)

____
Relationship to Patient

FOR OFFICE USE ONLY

Employee Health Services Quality Assurance

EHS Staff member to use a two person check process for identity validation below.
If your EHS Office is a single staffed office, quality control checks should happen at least 5 minutes apart and can be initialed by the same staff member.

Initial ______ I have checked the release of this record (via name, DOB, address or other means) and confirmed that the record being released is the correct record as per the above request.

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