AUTHORIZATION TO EXCHANGE MEDICAL INFORMATION and/or REPORT/S

EXPLANATION

This authorization to release medical information is being requested of you is to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et seq., of the California Civil Code and the HIPAA Privacy Rule.

Dr. Debra Dupree and her associates of Relationships at Work, Inc. are professional independent disability management consultants who will be facilitating your Interactive Process Accommodation meeting. Your employer will not receive the medical report/s requested below. We maintain strict confidentiality of medical information used only to provide thorough assistance with the reasonable accommodation process.

A. AUTHORIZATION

I hereby authorize: Name of Treating Physician_____ Phone #:_____
California to furnish to:

Dr. Debra Dupree of Relationships at Work, Inc. (and her designated agents) at 1520 First Street, K-306, Coronado, CA 92118, Fax 619-923-3611 or dr.dupree@relationships-at-work.com a medical reports pertaining to work injury or illness of :

Name of Employee: _____ Employer_____

DOB: _____ Last 4 digits of SS#_____ Claim # (if relevant)_____

B **I UNDERSTAND** that I have the right to limit the type of information to be released. I have indicated below the information which is authorized for release:

ANY OF THE FOLLOWING INFORMATION: Forms as requested, Medical provider Permanent and Stationary Report/s, return to work notes; Medical Specialist/s or QME/AME reports; Functional Capacity and Job Analyses; Activities of Daily Living OR _____

C. USES

This information supplied is to be used for the following purposes(s): To assess for Fitness for Duty and/or to more fully assist in determining reasonable accommodation for essential job duties

D. DURATION

This authorization shall become effective immediately and shall remain in effect until: one year past date below.

E. RESTRICTIONS

I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request.
Copy requested and received: Yes _____ No _____ Initials _____

G. SIGNATURE

Date:

Signed: _____
Printed Name:

H. Comments: