***Appendix 10.3, Confidential Medical Information Release Form***

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| **[*Organization Name]* OCCUPATIONAL HEALTH SERVICES** |
| **Authorization for Release of Confidential Medical Information** |
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| **TO:** *(Name of authorized occupational health person and address)* |
| ***You are hereby authorized to release information from the confidential medical/health records of:*** |
| **NAME:** |
| **EMPLOYEE ID NUMBER:** |
| **DATE OF BIRTH:** |
| **INFORMATION TO BE RELEASED:** |
| **PURPOSE:** |
| ***RELEASE TO:*** |
| **NAME:** |
| **ADDRESS:** |
| **DATE:**  **EXPIRY DATE:** |
| **SIGNED BY:**  **RELATIONSHIP:**  **(Employee or Legally Authorized Representative)** |
| **ADDRESS:** |
| **SIGNATURE OF WITNESS:**  **RELATIONSHIP:** |
| **ADDRESS:** |

***Authorization must be signed by the employee or by the legally authorized representative in the case of certified mental incompetence or death. This consent may be rescinded at any time prior to expiration date at request of the employee, except where action has been taken in reliance on the authorization.***