AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION RELATED TO OCCUPATIONAL HEALTH SERVICES

Name of employee, contractor, leased employee, supplier, etc. ("Individual"): _____

DOB: _____ **Address**: _____

Phone: _____ **Email**: _____

Employer or Organization Requesting Services ("Employer Organization"): _____

Occupation/Job Title: _____

The Employer Organization listed above has directed me to the health center operated by Quad/Med, LLC ("QuadMed") for occupational health related testing, evaluation, or treatment, including examinations, physicals, screenings, vaccinations, wellness services, or travel medicine. I understand that some or all of the information related to such services may be legally protected health information ("PHI"). **I authorize my PHI to be disclosed to the Employer Organization pursuant to the terms of this authorization.**

INFORMATION TO BE DISCLOSED:

My PHI disclosed pursuant to this authorization may include the results of testing (such as drug and alcohol tests or COVID tests), screening, evaluation, examinations (including assessments, diagnoses and medical history relevant to the tests and evaluations performed that the Employer Organization has ordered, requires, or that relates to a workers' compensation claim), and any treatment related information, including workers' compensation illness/injury treatment, vaccinations (including COVID vaccination information), travel medicine, or physical therapy. I understand that this information may include sensitive information about me such as alcohol or other substance abuse information, mental health information, HIV test results or related information, and/or other communicable disease information.

QuadMed may use my PHI for purposes of providing me with occupational health services and may disclose my PHI to the Employer Organization listed above to evaluate my suitability for initial and/or continued employment or other employment related matters.

MY RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

This Authorization is Required to Receive the Occupational Health Services. My receipt of the occupational health services may be conditioned on my signing of this authorization because the sole purpose of my visit to QuadMed is for QuadMed to create information to disclose to the Employer Organization for employment related matters. If I do not sign this authorization, QuadMed will not provide me with the specific occupational health services that have been requested. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.

Right to Revoke this Authorization. I understand that I have the right to revoke this authorization at any time. My revocation will not apply to uses and disclosures that have already occurred under this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to QuadMed, Attention: Privacy Officer, N64W23110 Main Street, Sussex, WI 53089. Revocation of this authorization may carry consequences related to my employment or prospective employment. I understand it is my responsibility to contact the Employer Organization for details.

Right to Inspect and Copy. I understand that I have the right to inspect or obtain a copy of the PHI I have authorized to be used and/or disclosed by this authorization. A processing and/or copying charge may apply as permitted by law.

Right to Receive a Copy of this Authorization. I have a right to receive a copy of this authorization.

Expiration. This authorization expires one (1) year from the date of my signature below.

NEW YORK RESIDENTS: If you are authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal and state law. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting your rights.

I have had an opportunity to review and understand the content of this authorization. By signing below, I am confirming that it accurately reflects my wishes and that I authorize QuadMed to use and disclose my PHI in accordance with the terms and conditions above.

Signature of Individual or Personal Representative	Relationship to Individual (Legal Authority)

Date of Signature