Student Health Services
Campus Box 7304, 2815 Cates Ave
Raleigh, NC 27695
Phone: 919-513-0277 Fax: 888. 972-4151

Faculty and Staff
Occupational Medicine Exam Request Form & Authorization for Release of Medical Information

Last Name_____First Name _____

Date of Birth _____ Department _____

Campus Tel. No. _____ E-mail Address _____

Supervisor_____Supervisor's Tel. No. _____

NCSU Employee Identification No._____

_____ Travel Clinic Services, include FAS no. _____

Effective August 1, 2011 a $25 fee will be charged for all appointments that are not kept and/or canceled at least one day in advance, or for same-day emergencies, called in by the supervisor on that day.

Privacy Protection Policy

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that the purpose of my visit is for the purpose of creating protected health information for disclosure to my employer, North Carolina State University. Should I refuse to sign this authorization, the examination requested will not be conducted, and certain tasks cannot be performed because they require a medical examination. If this task is an essential job duty, lack of performance may result in termination of my employment. I further understand that if the person(s) or organization authorized to receive the information is not a health plan or health care provider, the released information could be re-disclosed and would no longer be protected by federal privacy regulations.

1. Personal health information to be disclosed to other health providers: All medical information obtained as a result of the examination identified above.

2. Health Providers (or class of persons) or organization authorized to provide the information:

Student Health Services, Duke Occupational Medicine, and_____(write in name of health care provider if not listed above or N/A for not applicable).

3. Purpose of the requested disclosure: Summarized information to be disclosed by the health provider to those listed in item #4 below is to determine if the employee has a health condition which may interfere with his/her job performance and to comply with OSHA regulations.

4. Person(s) or organization authorized to receive summarized information: My supervisor, Safety Manager and the industrial hygiene section or Environmental Health and Safety occupational medicine program will receive only summarized information as described in item 3 above.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Student Health Services. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. I understand that I will get a copy of this form after I sign it.

7. I have been provided with a copy of NC State University's Notice of Privacy Practice prior to signing this authorization. A copy of the Privacy Practice is located also on the EHSC's Medical Surveillance webpage at: http://www.fis.ncsu.edu/health/docs/privacy.pdf.

8. This authorization expires in one year.

_____

Signature of Employee

Date: _____

_____

Signature of Supervisor **(REQUIRED for exam request)**

Date: _____