MACON & JOAN BROCK
VIRGINIA HEALTH SCIENCES
AT OLD DOMINION UNIVERSITY

Authorization for the Release of Medical Information

Complete and return to:
Virginia Health Sciences
Occupational Health
P.O. Box 1980
Norfolk, VA 23501-1980

I, _____, (print full name) hereby authorize Mason & Joan Brock Virginia Health Sciences at Old Dominion University, Department of Occupational Health, to disclose to (individual or organization that you want to receive your medical information) _____, the following medical information from my VHS Occupational Health record (check all that apply):

☐ Immunizations given
☐ TB skin tests and results
☐ Laboratory test results
☐ Chest x-ray results
☐ TB prophylaxis records
☐ Other (specify): _____

I give my permission for this medical information to be used only for the following purpose:

_____

_____

_____

This Authorization shall be valid (check only one):
☐ Indefinitely ☐ Until _____

Please note that:
Once disclosed, your medical information may be re-disclosed by the recipient individual or organization and may no longer be protected by law.

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that VHS at ODU has already disclosed information based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

I authorize VHS at ODU to disclose my medical information as indicated above:

_____ _____
Signature. I am the (check only one): Date

☐ Individual named above; or
☐ Personal representative of the person named above. Complete the following and attach appropriate documentation (i.e., Power of Attorney):
Name:
Address:
Phone:
Relationship or Authority: _____