CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

NAME: Anderson, Tiffany K **DOS:** 10/13/2005 10-13-05

DOB: 8/22/1970

CONSENT

I hereby authorize the Dameron Hospital occupational Health Department to:

- ☑ Obtain a complete medical history and physical examination including any required medical tests
- ☑ Provide medical treatment for a work-related injury
- ☐ Obtain a urine specimen and/or breath sample for drug and/or alcohol testing

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the Dameron Hospital Occupational Health Department to furnish to an agent, designee or representative of ***SJ Mosquito and Vector Control*** the results of my medical evaluation and/or treatment including past or present records pertaining to employment history, medical history, test results, urine drug and/or breath alcohol test results, services rendered or treatment provided to me.

USE

I understand that this medical information will be used for the purpose of determining my ability to perform the essential functions of my job with ***SJ Mosquito and Vector Control***.

RESTRICTIONS

I understand that ***SJ Mosquito and Vector Control*** may use these medical records only for employment-related purposes and that they 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.

DURATION

This authorization is effective immediately and shall remain in effect for one year from **10/13/2005**

ADDITIONAL COPY

I understand that I have a right to receive a copy of this form and that a copy of this document is as valid as the original.

I would like a copy of this form ☐ Yes ☑ No Received: ☐ Yes ☐ No Initial _____

SIGNATURE

Employee signature

Witness Signature

Date: 10/13/200

Non-DOT Drug Screens Only

List current meds: ☐ None

Rx: _____

_____

OTC: _____