HealthPartners Clinic

Authorization for Occupational Medicine Examination

My employer or potential employer has referred me to HealthPartners Occupational Medicine for the purpose of providing an examination to determine my fitness to work.

I request and authorize HealthPartners Occupational Medicine to provide this examination to me. I understand that HealthPartners Occupational Medicine will make a record of this examination, any findings and test results in my electronic medical record if I already have one, or will create an electronic medical record for me if I don't.

_____ _____

Signature Date

_____ _____

If employee is a minor: Parent/Guardian Signature Date

Authorization to Disclose Health Information

I request and authorize HealthPartners Occupational Medicine to give the results of this examination to my employer or potential employer:_____.

I understand that I am not required to authorize HealthPartners Occupational Medicine to disclose this information, but if I don't, my employer or potential employer may not hire me or allow me to work.

This authorization expires two years from the date written below. I understand that I can revoke this authorization in writing at any time, but revocation will have no effect if the information has already been disclosed. I understand that once my information is disclosed to my employer or potential employer, that information may no longer be protected by HIPAA.

_____ _____

Signature Date

_____ _____

If employee is a minor: Parent/Guardian Signature Date