



Sandia National Laboratories

Operated for the U.S. Department of Energy by

Sandia Corporation

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Authorization to Release Medical Information and Records

By Sandia National Laboratories Health Services

I, the undersigned, hereby authorize and request that Sandia National Laboratories Health Services furnish:

Any and all medical information in possession, including, but not limited to, charts, notations, correspondence, reports, photographs, and films.

The following Medical Information: _____

Pertaining to: _____ DOB: _____ MRN: _____

This information should be sent to:

The disclosure of medical information and records authorized herein is to be utilized for:

Any purpose, without limitation.

The purpose of: _____

I understand that my records are protected under Federal and State Confidentiality Regulation and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. This is an informed Authorization for the release of my medical information. I understand that this authorization is voluntary and may be revoked at any time by submitting a written revocation as provide below. This authorization does not extend to genetic information and no genetic information should be provided. I understand I have a right to receive a copy of this authorization upon request. A photocopy of this signed authorization shall be deemed as valid as the original.

By my signature, I understand that my authorization is subject to revocation in writing (Attn: Health Services Privacy Officer, MS-1019) at any time except to the extent that action was taken in reliance on this Release, if it is earlier revoked. Any such revocation must adequately describe this authorization and include this authorization's effective date. Notwithstanding any other provision of this authorization, this Authorization to Release Medical Information and Records shall terminate on _____ or for one year from the date of signature.

I understand that I am not required to sign this authorization to receive treatment or payment of benefits under any plan provided by Sandia National Laboratories Health Services. I further understand that my enrollment in and my eligibility for benefits under such plan are not conditioned on the signing of the authorization.

This information has been disclosed to you from records whose confidentiality is protected. You are prohibited from making any further disclosure of these records.

Date: _____

Signature: _____

(Employee/Legal or Personal Representative—specify relationship if signing as legal or personal representative)

There is no cost for the first (1st) complete set of medical records. Thereafter, a complete set of medical records will cost \$25.00; payable by check to: _____

_____ Initials of requester

For Medical Records Use Only

Date Copied: _____	By Whom: _____	Date Sent: _____	Log #: _____
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*OSHA regulations state records should be supplied within 15 working days of medical record department acceptance of this release.