

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby voluntarily authorize the release of my health information from my employer, Aerotek (the "Employer"), to MTS as follows:

(Please print clearly and complete all parts of this form. If you do not fill in the form completely, your request will not be processed and the incomplete authorization will be returned to you.)

I. Employee Information

Name: Rodney Lester Larson
Address: P.O. Box 44847, Eden Prairie, MN 55344
Phone: 1-952-960-1935
Employee #: 04995085

II. Identification of Person or Organization Receiving Information

My health information may be disclosed to the following person(s) or organization(s): *(attach more sheets if necessary)*

Name: MTS, Attention: David Solomon
Address: 14000 Technology Drive, Eden Prairie, MN 55344
Phone: 9529374825

III. Purpose(s) for the Release or Disclosure of Information

- ☐ At my request
☐ For completion of Client's OSHA 300 Log
☐ Other *(please specify)*: _____

IV. Description of Information to be Released or Disclosed *(check all appropriate)*

- ☐ Health records held by Employer in its capacity as your employer
☐ Other *(please specify)*: _____

V. Other Important Information

Your signature below means that you understand and agree to the following:

- ✓ The health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS), and/or genetic marker information. These records will be included in the information we will make available to the individual or organization you have identified above.
- ✓ You must sign this form in order for your request to release the information described above to be honored.
- ✓ The information disclosed may be protected by law. Information disclosed under this authorization is to be used only for the purposes of this authorization and no further purposes.
- ✓ You may receive a copy of this form if you ask for it in writing to the Employer.
- ✓ This authorization will expire one year from the date you sign this authorization.

VI. Signature of Individual or Individual's Representative

Signature of Individual or representative

Date

If this authorization is signed by an individual's representative,
the following additional information must be provided:

Name of personal representative (please print)

Relationship to the individual, including authority for status as representative

Name of the client at which the contractor is working

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby voluntarily authorize the release of my health information from my employer, **AEROTEK** (the "Employer"), to **CLIENT NAME** as follows:

(Please print clearly and complete all parts of this form. If you do not fill in the form completely, your request will not be processed and the incomplete authorization will be returned to you.)

I. Employee Information

Name: **EMPLOYEE FULL LEGAL NAME**
Address: **1234 Full Street Address**
City, STATE Zip Code
Phone: **(555)-555-5555**
Employee #: **01234567**

Contractor's full address, phone number and PeopleSoft employee ID number

II. Identification of Person or Organization Receiving Information

My health information may be disclosed to the following person(s) or organization(s): *(attach more sheets if necessary)*

Name: **CLIENT NAME, Attention: CONTACT PERSON (IF KNOWN) IF UNKNOWN, NA**
Address: **FULL STREET ADDRESS OF CLIENT, CITY STATE ZIP CODE**
Phone: **(555)-555-5555**

Client's name, contact person (if known) full address and phone number

III. Purpose(s) for the Release or Disclosure of Information

- ☐ At my request
☒ **For completion of Client's OSHA 300 Log**
☐ Other *(please specify)*: _____

To be checked "For completion of Client's OSHA 300 Logs"

IV. Description of Information to be Released or Disclosed *(check all appropriate)*

- ☒ **Health records held by Employer in its capacity as your employer**
☐ Other *(please specify)*: _____

To be checked "Health records held by Employer in its capacity as your employer".

V. Other Important Information

Your signature below means that you understand and agree to the following:

- ✓ The health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS), and/or genetic marker information. These records will be included in the information we will make available to the individual or organization you have identified above.
- ✓ You must sign this form in order for your request to release the information described above to be honored.
- ✓ The information disclosed may be protected by law. Information disclosed under this authorization is to be used only for the purposes of this authorization and no further purposes.
- ✓ You may receive a copy of this form if you ask for it in writing to the Employer.
- ✓ This authorization will expire one year from the date you sign this authorization.

Have contractor review this information

VI. Signature of Individual or Individual's Representative

EMPLOYEE SIGNATURE

Signature of Individual or representative

Date: **DATE FORM IS COMPLETED**

If this authorization is signed by an individual's representative, the following additional information must be provided:

Name of personal representative (please print)

Relationship to the individual, including authority for status as representative

Have contractor sign and date this section upon completion.

