AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EMPLOYER DIRECTED TESTING AND EVALUATIONS

By signing below, I authorize Priority One Drug Testing (PODT) to disclose my protected health information in accordance with the following terms and conditions:

1. PODT may disclose my protected health information to my employer or prospective employer, and/or continued employment; or other activity required by my employer, or law imposed upon my employer.
2. Name of current or prospective employer / designated entity: ________________________
3. My protected health information shall include the results of test(s) and/or evaluation(s), including diagnoses and medical history relevant to the test(s) and evaluation(s) performed that my employer or prospective employer has ordered or requires. This includes, but is not limited to drug or alcohol screens, physical examinations, mental or physical fitness-for-duty examinations, or other tests and evaluations required.
4. I understand that my health information may not be protected from further disclosure by any entity receiving my information under this authorization if they are not subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule or other State/Federal medical confidentiality laws, and that PODT has no control over subsequent disclosures.

MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION

- This authorization will expire on/or upon the later of; (a) one (1) Year from the date of my signature below (b) the date upon which my medical case has been closed and PODT has received full and final payment for services, or (c) when I am no longer employed by the above named employer.
- I may review or obtain a copy of the health information that will be disclosed pursuant to this authorization. A processing and/or copying charge may apply as permitted by law.
- My treatment may not be conditioned on my signing of this authorization unless the sole purpose of my visit(s) to PODT is for my employer, prospective employer or their designated third-party to obtain health information about me.
- I may revoke this authorization at any time, but I must do so in writing and submit the revocation to the clinic where I receive services. My revocation will take effect upon receipt, but shall not apply to disclosures that have already occurred based upon this authorization. Revocation of this authorization may carry consequences related to your employment or prospective employment. Contact your employer for details.
- I have a right to not sign this authorization and/or to limit the information I authorize to be disclosed. However, refusal to grant this authorization or not permit the release of information that your employer requires may violate a condition of employment or prospective employment. Contact your employer for details.
- I have a right to receive a copy of this authorization.

Patient Signature: ____ Date: ___________

Patient Name: ____ Date: ___________