HUMAN RESOURCES

Authorization Form for the Use and/or Disclosure of Protected Health Information

I authorize _____ to and/or disclose my
(Name of Physician or Medical Provider)
protected health information as described below.

1. I authorize the disclosure of my protected health information to the following entity/persons:

   Neighbors in Need of Services, Inc.
   PO Box 189
   Rio Hondo, Texas 78583

   Purpose for obtaining this information:
   Initial or Annual Health Examination Results

2. This authorization expires upon: _____
   (Insert date or event)

3. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by the person or entity and would no longer be protected.

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

5. I understand that I may inspect or copy any information to be used or disclosed based upon this authorization.

6. I certify that I have received a copy of this authorization.

If no date or event is stated above, this authorization is effective only for twelve months after the date of execution.

_____ _____
Signature Date

_____ _____
Printed Name Last 4 digits of SS#

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Initial/Annual Health Examination Results

This health examination form must be completed in English and signed by a qualified physician after reviewing the examinees medical history, conducting a health examination, testing for tuberculosis and screening for any communicable diseases.

1. Employee Name:_____ Date of Birth:____/_____/_____

2. Height: _____ 3. Weight: _____ 4. Corrected Vision: 20/____ 20/____
   Left Right

5. Blood Pressure: _____ 6. Pulse Rate: _____ Regular or Irregular

7. Other medical/laboratory tests performed: _____

   Results: _____

8. Health Conditions/Symptoms warranting reference or follow up: _____

   _____

9. Physician's Certification:
   I have completed a health examination on the person named above and have reviewed this person's medical history, laboratory evaluations, and tuberculin skin tests. I certify that this person is free of active tuberculosis and any other communicable diseases.

   Name of Physician: _____
   Print Name

   Address: _____ Telephone: _____

   Signature: _____ Date: _____

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Tuberculosis Test

This is to certify that_____ Date of Birth: ____/_____/_____
(Employee Name)

was examined by me for:

Tuberculin Skin Test

Purified Protein Derivative (PPD) Test

Test Administered on: ____/_____/_____

Test read on: ____/_____/_____

Results for TB: Negative _____ Positive _____

Chest X-Ray

Test Administered on: ____/_____/_____

Results for TB: Negative _____ Positive _____

Remarks:

_____

_____

_____ _____
Name of Clinic or Physician Address

_____ _____
Signature of Physician City, State, Zip

_____
Date