Occupational Health Services

I,___________________________________,DOB____________ DO HEREBY AUTHORIZE
(PRINT NAME)

OCCUPATIONAL HEALTH SERVICES TO RELEASE INFORMATION RELATING TO ME TO THE FOLLOWING: (please print complete name and address of person receiving information)

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DATE(S) OF SERVICE____

Information to be Released:

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SIGNATURE____

DATE____

Please note: This authorization will expire in 90 days from date of release.

www.oswegohealth.org
315-349-5676 Fax: 315-349-5726
140 West Sixth Street, Suite 180 Oswego, New York 13126

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r/ forms/release from Occ Health