



Occupational Health Services

AUTHORIZATION FOR RELEASE OF INFORMATION

I, THE UNDERSIGNED, DO HEREBY REQUEST AND AUTHORIZE _____

TO RELEASE INFORMATION RELATING TO ME TO THE FOLLOWING:

Occupational Health Services
Oswego Hospital
140 West Sixth Street, Suite 180
Oswego, New York 13126
Phone: (315) 349-5676 Fax: (315) 349-5726

DATES OF SERVICE _____

CHECK THE FOLLOWING INFORMATION TO BE RELEASED:

- HISTORY AND PHYSICAL
- LAB REPORTS
- EKG REPORT
- X-RAY REPORT
- AUDIOGRAM
- PFT
- OTHER _____

PRINT NAME _____ DATE OF BIRTH _____

SIGNATURE _____

DATE _____