



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)

DATE(S) OF SERVICE _____

Information to be Released:

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