



Lucile Packard
Children's Hospital
Stanford

Authorization for Release of Information

I (print name clearly) _____
First Last

Date of Birth: ____/____/____ Phone/Cell#: _____

I hereby give my consent to Occupational Health Services at Stanford Hospital and Clinics and Lucile Packard Children's Hospital to release the following medical surveillance information. (Please check all that apply)

- All vaccinations and titers as they relate to hospital medical surveillance
- All tuberculosis screening examinations including blood tests, skin tests and x-rays.
- Tuberculosis screening questionnaire (the last one completed)
- N95 Fit testing results.

I understand I have the right to receive a copy of this Authorization and any photocopy or facsimile of this authorization shall be considered as the original.

Please send my information to the following person/organization:

By the following method of delivery:

- Fax to the following number: _____
- E-mail (SHC/LPCH addresses only)
SHC/LPCH e-mail address: _____
Rewrite SHC/LPCH e-mail address: _____
- Send via home mailing address: _____

I understand that I may revoke this authorization at any time in writing if signed by me and delivered to Mary Spangler, Occupational Health at SHC MC 5205.

Signature _____
Employee's name Date

**FAX THIS FORM TO (650) 618-8661 or email
occhealth@stanfordhealthcare.org**

Due to high volume of requests. Please allow 7-10 working days!!