CLEAR PRINT **SAVE**

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF OCCUPATIONAL SAFETY & HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The State of California Division of Occupational Safety and Health (DOSH) protects the health and safety of employees by requiring employers to follow workplace health and safety laws. To aid DOSH in investigating workplace injuries and illnesses, state and federal laws require medical providers to furnish DOSH with the medical records of workers who have suffered workplace injuries or illnesses. By signing this authorization, you assist DOSH in obtaining your records in the most efficient manner.

Privacy Notice: For information about how the Department of Industrial Relations (DIR) and DOSH use and protect personal information, please see DIR's Privacy Policy at https://www.dir.ca.gov/od_pub/privacy.html. If you have any questions regarding this form, please contact:

Name	Email	Phone

PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

INSURANCE OR MEDICAL NUMBER: _____

COMPANY: _____

Provider: Please send medical information, **along with a copy of this form to**:

Paul Papanek, MD MPH
Cal/OSHA Medical Unit
3939 N. Atlantic Ave., Suite 212
Long Beach, CA 90807

NOTE: DOSH is exempt from the California Medical Information Act (Civil Code section 56, Civil. Code section 56.30 (e) and (h)) and the Federal Health Insurance Portability and Accountability Act (HIPAA) (Title 45 CFR section 164.512). This release complies with Civil Code section 56.11.

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I, _____, hereby authorize:
(Full Name of Patient.)

_____
(Full Name of Health Care Provider or Medical Facility.)

_____
(Provider/Facility's Address, City, State, Zip Code, and Phone Number)

to release to **the California Division of Occupational safety and Health** all records pertaining to my workplace injury or illness in association with _____ while employed by _____,
(Event/condition) (Company Name)
including, but not limited to, my related medical history, dates and results of medical exams and treatment given, all notes reflecting history and physical examination findings, x-ray results if any, and/or pathology (biopsy) results, if any, given on or after _____.
(Date of Injury/Onset of Symptoms)

I authorize the release of the above medical records for DOSH's official use, including investigating, reviewing and determining violations of workplace health and safety laws, and participating in administrative, civil and criminal proceedings involving my employer. This authorization shall remain valid as long as necessary for DOSH to do the work described above, but no longer than 3 years from the date of my signature. This authorization includes any future medical records, not yet created, that concern my workplace injury or illness identified above. I hereby request ☐ or decline ☐ a copy of this authorization.

Patient Signature: _____ Date: _____

Or if Signed by Personal Representative on behalf of Patient:

_____ Date: _____
Signature Name Relationship to Patient

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