MEDAC
CORPORATE HEALTH

AUTHORIZATION
TO RELEASE INFORMATION

_____
Name of Company to Whom Information will be Released

I, (please print your name) _____, hereby authorize Medac Health Services, P.A., d/b/a Medac Corporate Health Services ("Medac"), its physicians, employees, and agents to release the results of my examinations and tests to the above named company. This includes the results of any drug or alcohol tests, the results of any physical examination, my medical history, and all other health information obtained by Medac in conjunction with these tests and examinations, including information regarding substance abuse, sickle cell anemia, psychological or psychiatric impairments or HIV status. I understand that the above information will be used or disclosed in connection with my fitness for employment with the above named company.

This authorization will automatically expire within 180 days from the date of this authorization. I understand that I have a right to revoke this authorization by requesting revocation from Medac in writing. I acknowledge that I have received or been offered a copy of Medac's notice of privacy practices. I acknowledge that, unless I sign this authorization, Medac cannot perform the requested tests or examinations on me. I understand that Medac will disclose the health information to the above named company only, but that the health information may be redisclosed by the above named company to others without my consent or knowledge and, in such event, may lose its protection under federal or state privacy regulations.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Witness Date