AUTHORIZATION FOR MEDICAL PROVIDER TO RELEASE MEDICAL INFORMATION

I hereby authorize the medical or other service provider identified below to release all job-related medical information about me, including any drug and alcohol related information and participation in substance abuse programs, as requested by the Multnomah County Drug and Alcohol Coordinator.

_____

Name of medical or other service provider

_____

Address of medical or other service provider

_____

Phone number of medical or other service provider

_____

Employee Signature Date

_____

Employee Social Security Number

Filing Instructions: Authorization to Release Medical information shall be maintained as part of the employee's confidential medical file by the Multnomah County Drug and Alcohol Coordinator.