RELEASE OF MEDICAL RECORDS

I hereby give permission to the Occupational Medical Service (OMS), National Institutes of Health, to release a portion of my medical record. Please note: OMS must receive original signatures; copied forms and faxed versions are not acceptable.

Define the records you want OMS to release:

_____

_____

Identify who you want to receive your records:

_____ _____
Name Telephone number

_____ _____
Street address City, State, Zip Code

_____
Fax number, if applicable

Provide the following personal information:

_____ _____ _____
Last name (please print) First name MI

_____ _____
Last 4 digits of your SSN Date of Birth

_____ _____
Signature Date

_____ _____
Witness' signature Date

Authorization for OMS to fax your records (Note: OMS will not fax more than 10 pages)

_____
Signature

OMS staff provides the following information:

_____ _____
Signature of the person providing the service Date completed

Occupational Medical Service
National Institutes of Health
10 Center Drive, Room 6C306
Bethesda, MD 20892-1584