NSSP releases

National Supplemental Screening Program

Authorization for Release of NSSP Participant Information – Private Physician

NSSP Participant's Name: _____ Date of Birth: _____

I hereby authorize Oak Ridge Associated Universities to release the results of my National Supplemental Screening Program medical examination to my private physician, whose name and address are listed below:

_____

Personal Physician's Name Address City State Zip

Personal Physician's Telephone Number: _____

Oak Ridge Associated Universities may disclose the above named participant's NSSP examination information as described below.

The following results/reports from exam date _____ are to be released to the physician listed above:

☐ **All results/reports**

Includes all testing results, medical history, and summary cover letter.
Do not check any other boxes if you select this option

OR

☐ **Only the results listed below** (check all that apply)

- ☐ *Physical examination*
- ☐ *Breathing test*
- ☐ *Chest x-ray (B read)*
- ☐ *Laboratory results*
- ☐ *Beryllium test (BeLPT)*
- ☐ *Hearing test*
- ☐ *Vision test*
- ☐ *Medical history*

This authorization is voluntary and I may rescind my authorization of this release in the future. I will personally receive a copy of the medical information that is to be disclosed to my personal physician. Any information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. There is no processing fee for this service. This authorization will expire one year from the date I sign this authorization unless I specify otherwise.

I may revoke this authorization at any time by notifying Oak Ridge Associated Universities. To revoke this authorization, I must do so in writing and the written revocation must be signed and dated. The revocation will not affect any actions taken before its receipt by Oak Ridge Associated Universities.

_____ _____

Signature of NSSP Participant or Representative Date

Printed Name of NSSP Participant or Representative: _____

_____ or _____

Representative Relationship to Patient Legal Authority (attach supporting documentation)