ArcelorMittal

Authorization for Release of Medical Records/Health Information (Rev. June 2013)

Employee Name _____ Phone _____

Employee SSN or Alternate ID _____ Date of Birth _____

Complete Address _____

_____

I authorize: _____

_____

to release to: _____

_____

Please check one of the following boxes:

☐ All medical records and information maintained in my medical record; or

☐ Medical records and information pertaining to the following activity(ies) or incident(s):

_____

_____

_____

I understand that this information will be disclosed to the recipient for the following purpose:

_____

I understand that I may refuse to authorize the release of any health information and that my refusal to do so may prevent the disclosure of such information. My ability to receive treatment/ payment, enrollment or eligibility for health insurance benefits will not be conditioned on whether or not I sign this authorization. I understand that this health information may include details regarding physical and/or mental health, HIV status, and alcohol and/or drug abuse, unless specifically excluded above.

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless I revoke this authorization, or set forth a different time period, it will expire one year from the date signed below. Instead of the automatic expiration of this authorization one year from the date signed below, this authorization shall expire:

_____

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that, because the recipient may not be receiving the information in the capacity of a health care provider or health plan covered by HIPAA, it is possible that the information described above may be re-disclosed and may no longer be protected by HIPAA.

X_____ X_____

Signature Date