Authorization for Release of Health Care Information

DMA Form 5.3-1-R (Jun 2016)

Wisconsin Department of Military Affairs
Confidential Fax (608) 242-3168

Employee Name	Birth Date - Used for Identifying Record
Doctor / Health Care Provider Name	
Clinic Name - If Applicable	
Clinic / Office Address	
Clinic / Office City, State, Zip Code	Clinic / Office Area Code - Telephone Number ***and*** Fax Number

I authorize the above identified Doctor/Health Care Provider to release to my employer, the Wisconsin Department of Military Affairs, information from my health care records as it pertains to my ability to perform the duties and responsibilities that I have been assigned.

I understand the types of information and records that may be disclosed include, but are not limited to: notes, reports, correspondence, test results, recommendations, and evaluations, relating in any way to my treatment or care. These are intended to include both physical and/or mental health records.

I understand that this information may be disclosed to the Director of the State Human Resource Office of the Department of Military Affairs, to the Department's Risk Manager, to specifically designated managers of the Department of Military Affairs as authorized by the State Human Resource Director with a business need to know, to other health care providers, and to the following specifically identified person(s):

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In addition, I understand that this information may be disclosed to Department of Military Affairs Central Payroll, only as necessary, for retirement and disability purposes. This authorization is provided so that my employer may evaluate my request for leave of absence, fitness to work, and/or accommodation.

This authorization is effective for six months from the date signed.

_____ _____

(Employee Signature) (Date)

Medical Consent

DMA Form 5.3-2-R (Jun 2016)

I, the undersigned, consent to undergo a medical examination, including blood specimens, x-rays, skin tests, immunizations, drug screen examinations, and other examinations which the examiners may consider necessary to complete the medical evaluation.

_____ _____

(Applicant Signature) (Date)