



Medical Records Release

I, _____, acknowledge and understand that Primo Healthcare Services and its client facilities require medical documentation reasonably necessary to make decisions regarding my employment. I agree to provide all requested medical documentation relating to any requested or required accommodation to Primo Healthcare Services. I authorize Primo Healthcare Services to share requested medical documentation with the company's affiliates and client facilities. Neither Primo Healthcare Services, nor its client facilities will further disclose medical documentation released pursuant to this authorization, unless further expressly authorized by me or required by law. This authorization shall become effective immediately and shall remain in effect for three (3) years. I understand that I have the right to receive a copy of this authorization upon request.

Healthcare Professional Signature

Date

Healthcare Professional Name Printed

Date

Work- Related Allergies and Accommodations *(At least one box must be checked)*

None Powder Latex Other: _____

Accommodations/Limitations *(required if powder/latex/other were checked above, check all that apply)*

Latex-Free Gloves Powder-Free Gloves Latex & Powder Free Gloves