



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com

For AMO Official Use Only

Received Date: _____

Received By: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR PRE-EMPLOYMENT PURPOSES

In order for the AMO Medical Center (the "Medical Center") to disclose Protected Health Information ("PHI") to your employer for pre-employment purposes, you must complete this Authorization Form and return it to the Medical Center. PHI is information that is created, received, transmitted or stored by the Medical Center which relates to your past, present, or future physical or mental health, health care, or payment for health care and either identified you or provides a reasonable basis for identifying you. Except as permitted by law, the Medical Center may not use or disclose PHI to persons other than those you specify on this or other Authorization Forms. Because the provision of the treatment indicated below is solely for the purpose of creating Protected Health Information for disclosure to a third party, the Medical Center may condition the provisions of such treatment/services on your signing this Authorization Form.

PART 1: REQUIRED INFORMATION

Participant's Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:

PART 2: AUTHORIZED PERSON

I hereby authorize the AMO Medical Plan to disclose the PHI identified in Part 3 of this form to the following employer(s):

Company/ Employee Name:		
Telephone Number:	Fax Number:	
Street Address:		
City:	State:	ZIP Code:

PART 3: DESCRIPTION OF THE INFORMATION TO BE DISCLOSED

I authorize the AMO Medical Center to disclose PHI (including written, electronic, or oral information) to the person (s) identified in Part 2 of this form in connection with the following. (Mark all that apply.)

Check here if Test/ Physical applies	Test and/or Physical	Date of Test/ Physical
<input type="checkbox"/>	EKG	mm/dd/yyyy:
<input type="checkbox"/>	Chest X-Ray	mm/dd/yyyy:
<input type="checkbox"/>	Benzene (Lab, PFT, Card)	mm/dd/yyyy:
<input type="checkbox"/>	Drug Test (DOT, Card)	mm/dd/yyyy:
<input type="checkbox"/>	Shot/ Immunizations Record	mm/dd/yyyy:
<input type="checkbox"/>	Lab Work	mm/dd/yyyy:
<input type="checkbox"/>	Other Medical Studies	mm/dd/yyyy:
<input type="checkbox"/>	MSC Physical	mm/dd/yyyy:
<input type="checkbox"/>	CG or Marshall Island Physical	mm/dd/yyyy:
<input type="checkbox"/>	All Records	mm/dd/yyyy:

PART 4: PURPOSE OF THE USE OR DISCLOSURE

The purpose of this disclosure is to provide the Employer referenced in Part 2 of this Authorization Form with pre-employment medical information about me.

PART 5: VALIDITY OF AUTHORIZATION FORM

This Authorization is valid for the following period checked, or until I cancel the Authorization by completing a Cancellation of Authorization form, whichever occurs first:

<input type="checkbox"/>	One year from date of signing (this selection will necessitate an updated Authorization at the end of the expiration period)
<input type="checkbox"/>	More than one year, ending on _____ (this selection will necessitate an updated Authorization at the end of the expiration period.)
<input type="checkbox"/>	Other event or time (please specify) _____

PART 6: ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and understand the following:

- I have the right to refuse to sign this Authorization, however, because the provision of the treatment above is solely for the purpose of creating Protected Health Information for disclosure to the Employer referenced in Part 2 above, the Medical Center may condition treatment on receipt of an Authorization.
- I have the right to revoke this Authorization at any time by submitting a Cancellation of Authorization form to:

American Maritime Officers Plans
Privacy Officer
2 West Dixie Highway
Dania Beach, Florida 33004

- Revocation (Cancellation of Authorization) is only effective after it is received and logged by the AMO Medical Plan's Privacy Officer. I understand that that any use or disclosure made prior to the revocation under this Authorization will not be affected by a revocation.
- I understand that after PHI is disclosed, it may no longer be protected under the Federal Privacy Regulations and the recipient of the PHI may disclose it again.
- I understand that I am entitled to receive a copy of this Authorization.

Participant Signature:

Date:

NOTARY PUBLIC

STATE OF _____)
COUNTY OF _____)

The foregoing instrument was acknowledged this _____ day of _____, 20____, by _____ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

Signature of Notary Public

Print, Type, or Stamp Commissioned Name of Notary Public

Date Commission Expires

NOTARY SEAL

Personally Known

Produced Identification

Type of Identification: _____