

**AUTHORIZATION FOR TRANSMISSION OF MEDICAL RESULTS**

This statement authorizes Ingalls Occupational Health to transmit medical results or other information via confidential facsimile machine or computer to \_\_\_\_\_ (Company), hereinafter referred to as "the Company."

This authorization will affirm the Company's desire to have information supplied via confidential fax or computer from their designated occupational health provider.

The Company further agrees to take full responsibility for the confidentiality of all medical information supplied by fax or computer access. Information provided via fax will not be mailed.

The Company agrees to notify Ingalls Occupational Health in writing of any changes in contact information such as: e-mail address, fax number, authorized representatives to receive results, or to provide notice to discontinue receiving information in this fashion.

***Please print:***

\_\_\_\_\_  
Authorized Company Representative

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Title

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Addtl. Fax Number / E-Mail address

Additional Authorized Representatives  
\_\_\_\_\_

\_\_\_\_\_