Beyond Wellness

Chiropractic Center

FMCSA exemption authorization for release of information

For your DOT visit at Beyond Wellness

Dr. Kevin P. Lyons, DC
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Charlotte, NC 28269
Office: 704-461-1836
Return fax: 704-246-5156

Federal application instructions remain in effect

Follow the attached FMCSA submission instructions. This clinic cover sheet does not change the federal recipient or submit an application. If copies are requested for your DOT examination, contact Beyond Wellness to arrange their return.

Read both authorization pages: the FMCSA form concerns disclosure of medical information in a public docket. It is not a routine clinic records release or permission to text.

For the applicant in an FMCSA exemption application. Read both pages: it addresses disclosure of medical information in a public docket. It is not the clinic's routine records release or permission to text.

Complete only the sections assigned to you. Clinical findings, signatures, dates and qualification decisions have not been completed by the clinic in this packet.

F M C S A

Federal Motor Carrier Safety Administration

www.fmcsa.dot.gov

AUTHORIZATION FOR RELEASE OF INFORMATION

APPLICANT IDENTIFICATION

Name: _____

Date of Birth: _____

Protected Health Information: Any information that can be linked back to the individual applicant, can be in any form: written, electronic, or verbal.

(Signed original will be placed in the applicant's record and a copy provided to the applicant)

I __(NAME OF APPLICANT) __ authorize the Federal Motor Carrier Safety Administration ("FMCSA" or "the Agency") to disclose, in a public docket accessible to all interested parties via the Internet, medical records and information related to my application for an exemption from one or more of the physical qualifications standards under 49 CFR 391.41. I understand that the medical records and information that will be disclosed by the Agency may include specific health information related to the medical conditions or illnesses, injuries, diagnosis, prognosis and medical treatment provided to me which have resulted in my not being able to obtain a medical certificate to operate commercial motor vehicles in interstate commerce. I understand that the American Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain protections against the release of my personal medical records and information and hereby waive all protections provided by HIPAA with regard to medical records and information related to my application for an exemption from certain requirements under 49 CFR 391.41.

Please check and initial the statement that applies: ☐ I do _____ ☐ I do not _____ authorize this information to be released.

Information Limitations, if any: _____

This information may also be shared with (please check one of the following)**:**

1. ☐ Legal Representative _____

2 ☐ Other (please specify):

_____

Please note this document has two pages, you are required to read and complete information on both documents, the last page will require your complete signature first/last name and date.

Description of the exemption being sought and the medical information to be released to FMCSA in support of the exemption application, including the healthcare professionals responsible for providing the records that will be released.

_____
_____
_____
_____

I understand that I may refuse to sign this authorization and that my refusal to sign may affect my ability to obtain an exemption with the FMCSA. I understand that I may withdraw my application for an exemption at any time and that I may revoke this authorization in writing at any time prior to the FMCSA publishing a notice in the Federal Register soliciting public comments on my exemption application. I understand that after FMCSA publishes a notice in the Federal Register all medical records and information submitted to FMCSA will be submitted to a public docket accessible by all interested parties via the Internet. The Agency will not remove information from the public docket after it has been posted.

□ **Applicant's Address** □ **Signing person Name, Address & Telephone #:**

Name(s) _____

Address _____

Telephone # _____

Request sent to:

1. □ **Physician** □ **Company** □ **Person** □ **Other (explain)**

_____
_____

2. Address: _____

3. Phone Number: _____ **Fax #:** _____

***** □ **Signature of Applicant** □ **Signing Person** □ **Legal Representative:**

_____ **Date:** _____

Relationship to applicant: _____

All Facilities/persons listed on pages 1, 2 of this form may share information among and between themselves for the FMCSA assessment and Quality Assurance. Please sign above to authorize.