ALT ER TRADING CORPORATION

ACCESS TO EMPLOYEE EXPOSURE AND MEDICAL RECORDS POLICY & PROCEDURE

PURPOSE

The purpose of this policy is to provide employees, and their designated representatives, the right of access to relevant exposure and medical records. It is also to provide representatives of the Assistant Secretary a right to access these records in order to fulfill responsibilities under the Occupational Safety and Health Act.

SCOPE AND APPLICATION

This policy applies to all employee exposure and medical records made or maintained in any manner. Each facility shall assure that the preservation and access requirements of this policy are complied with regardless of the manner in which the records are made or maintained. Records will be made available within 15 days after completing the required Alter form or notice of a delay, and the reason for such, will be given to the requestor.

SPECIFIED WRITTEN CONSENT

The employee requesting the release of their medical information shall include the following elements in their written authorization:

- The name and signature of the employee authorizing the release of medical information.
- The date of the written authorization.
- The name of the individual or organization that is authorized to release the medical information.
- The name of the designated representative (individual or organization) that is authorized to receive the released information.
- A general description of the medical information that is authorized to be released.
- A general description of the purpose for the release of the medical information.
- A date or condition upon which the written authorization will expire (if less than one year).
- A written authorization does not operate to authorize the release of medical information not in existence on the date of written authorization, unless the release of future information is expressly authorized, and does not operate for more than one year from the date of written authorization.
- A written authorization may be revoked in writing prospectively at any time.
ALTER TRADING CORPORATION
WRITTEN REQUEST FOR ACCESS / RELEASE OF MEDICAL RECORDS

I, _____________________________, (full name of worker/patient) hereby authorize Alter Trading Corporation to release to ______________________________ (individual or organization authorized to receive the medical information), the following medical information from my personal medical records:

_____________________________________________________________________________________
_____________________________________________________________________________________

(Describe specifically the information that is being requested to be released).

I give my permission for this medical information to be used for the following purpose:

_____________________________________________________________________________________
_____________________________________________________________________________________

However, I do not give permission for any other use or re-disclosure of this information.

This authorization expires as of ___________________________________________.

The following medical information in Alter Trading Corporation’s possession is hereby specifically not authorized to be released as a result of this authorization:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Full printed name of Employee or authorized Legal Representative
_____________________________________________________________________

Signature of Employee or authorized Legal Representative
_____________________________________________________________________

Date of Signature ________________________

Note: Copy of authorization / declaration as legal representative must be provided for non-employee request at such time the request is made.

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This is to inform you that you have the right of access to your exposure and medical records. Please contact your Human Resources Department if you have any questions concerning this matter.

Trainer Signature: _____________________________________________________

Employee Printed Name: ________________________________________________

Employee Signature: ___________________________________________________

Employee Social Security Number: ________________________________________

Date: __________________________________________________________________