UNITED STATES STEEL CORPORATION
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(General Form for use by all United States Steel Corporation Medical Departments)

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of health information. Covered entities (as defined by applicable law) must obtain a signed authorization from the individual or the individual's legally authorized representative to disclose that individual's health information. Authorization is not required for disclosures related to treatment, payment, healthcare operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits, except in connection with disability benefits (e.g., Sickness & Accident) or where otherwise permitted by applicable law. In certain cases, where information is necessary for employment-related purposes or activities (e.g., employment drug testing), your refusal to sign may have employment consequences.

NAME OF PATIENT OR INDIVIDUAL

Last ______ First ______ Middle ______

OTHER NAME(S) USED ______

DATE OF BIRTH Month ______ Day ______ Year ______

U. S. STEEL EMPLOYEE ID OR PAYROLL NUMBER ______

ADDRESS ______

CITY ______ **STATE** ______ **ZIP** ______

PHONE (___) ______ **ALT. PHONE** (___) ______

EMAIL ADDRESS (optional) ______

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S HEALTH INFORMATION:

Any employee, volunteer, contractor, or other agent of United States Steel Corporation and its affiliated entities, including the Medical Department(s).

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

United States Steel Corporation Legal Department ☑ (check here for yes), and Kelly Cain-Jackson, US Steel paralegal

Person/Organization Name RECORDS DEPOSITION SERVICE, INC.

Address PO BOX 5054

City SOUTHFIELD State MICHIGAN Zip 48086-5054

Phone (248) 357-3330 Fax (248) 357-3337

REASON FOR DISCLOSURE
(Choose only one option below)

- ___ Treatment/Continuing Medical Care
- ___ Personal Use
- ___ Billing or Claims
- ___ Insurance
- ☑ Legal Purposes
- ___ Disability Determination
- ___ School
- ___ Employment
- ___ Other ______

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed, whether created now or in the future. The signature of a minor patient is required for some of these items. If all health information is to be released, then check only the first box.

☑ All Health Information	__ History/Physical Exam	__ Past/Present Medications	__ Lab Results
__ Physician's Orders	__ Patient Allergies	__ Operation Reports	__ Consultation Reports
__ Progress Notes	__ Discharge Summary	__ Diagnostic Test Reports	__ EKG/Cardiology Reports
__ Pathology Reports	__ Billing Information	__ Radiology Reports & Images	__ Other ______

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)	_____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records	_____ HIV/AIDS Test Results/Treatment
_____ Sexually Transmitted Disease Records	_____ Reproductive Care Records

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual or the individual reaching the age of majority, or the following specific date (optional): Month ______ Day ____ Year _____. However, this authorization will expire earlier where required under applicable state law.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to United States Steel Corporation – Headquarters Medical Department. I understand that prior actions taken in reliance on this authorization by entities that had my permission to disclose/access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE ______ ______
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): ______

If representative, specify relationship to the individual: ____Parent of minor ____Guardian ____Other ______

A minor individual's signature is required for the release of certain types of information, including, for example, information related to certain types of reproductive care, sexually transmitted diseases, drug, alcohol, or substance abuse, and mental health treatment.

SIGNATURE ______ ______
Signature of Minor Individual **DATE**