Authorization for Disclosure of Protected Health Information

Patient Information

Patient name: ____

Patient date of birth:____

Phone number: ____

Release Information

Release Information From:
(*name of individual*)

____

Release Information To:

Constance F. Griffin, RN

Valley Central School Nurse Coordinator / Safety Coordinator

Purpose of Release

This authorization will allow Horizon Medical Group to work with your employer/school to discuss and coordinate my care for COVID-19 testing including COVID test results.

Information to be Released

Medical Information

Any lab test results relating to COVID-19 screening, including back to work recommendations.

Service Dates

Any visits from the date I sign this form and one year forward.

Expiration/Effective Dates

This consent will expire one year from the date I sign it. This authorization applies to any lab tests results related to COVID-19 screening after the date of my signature.

I may revoke this consent at any time by sending written notice to the Horizon Family Medical Group. I understand this consent is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

Signature: ____

Date signed (required):____

Relationship, if not patient: ____