Healthcare Solutions Center, LLC

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Please complete all sections of this HIPAA Authorization form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

_____, give my permission for **Healthcare Solutions Centers, LLC and their staff** to share the information listed in Section 1 of this authorization with the organization specified in Section 2 of this authorization.

Section 1. Health Information to be Disclosed.
Disclosure of my first and last name, date of birth and the fact that I have been advised by a health care provider to take time off of work due to potentially being exposed to or being infected with COVID-19.

Section 2. Who Can Receive My Health Information.
I give authorization for the health information detailed in Section 1 of this authorization to be shared with the following organization:
Organization/Employer Name: _____.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and may no longer be protected by state law or HIPAA Privacy Rules.

Section 3. Duration of Authorization, Purpose and Other Terms.
The purpose of this authorization is to inform my employer of my potential exposure to or infection of COVID-19. This authorization shall be effective for six (6) months from the date verbal agreement or signature, unless this authorization is revoked, as described below. I understand that I am permitted to revoke this authorization at any time and can do so by submitting a request to Healthcare Solutions Centers, LLC. I further understand that in the event that the information described in Section 1 has already been shared by the time my authorization is revoked, Healthcare Solutions Centers, LLC cannot take back such disclosure. I understand that I do not need to give any further permission for the information detailed in Section 1 to be shared with the organization in Section 2. I understand that the failure to sign/submit this authorization, or the withdrawal of this authorization, will not prevent me from receiving any treatment or benefits I am entitled to receive, provided that this information is not required to determine if I am eligible to receive those treatments or benefits.

Section 4. Signature

_____ _____

Printed name of the Individual Giving this Authorization | Date of Birth

_____ _____

Signature of the Individual Giving this Authorization | Date

If this authorization is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Relationship to Patient and Printed name of the person completing this form:

_____ _____

Signature of person completing this form: _____

If you have any questions regarding Healthcare Solutions Centers, LLC HIPAA policy,
Please contact our HIPAA officer at (602) 424-2101.