AUTHORIZATION FOR DISCLOSURE OF EMPLOYMENT RELATED RECORDS

I hereby authorize Providence Caregiver Health Services *to disclose the following from the employment records of:*

Caregiver Name (last, first, middle)**:** _____ **ID#:** _____
Previous Name (if applicable)(last, first, middle)**:** _____
Parent/Legal Guardian Name (if applicable)**:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone: _____ **Date of Birth:** _____
Dates of Employment: _____
Records to be disclosed to (Name): _____

Preferred Method of Communication:

- ☐ **US Postal Mailing Address:** _____
- ☐ **Fax # (include area code):** _____
- ☐ **Email Address:*** _____
- ☐ **Caregiver Obtained Records In Person:** _____ **Date:** _____

**If you have chosen a private email address as your preferred method of communication, by signing below, you consent to receive your Protected Health Information (PHI) through this channel.*

Information to be disclosed:

- ☐ TB Test (IGRA/PPD)
- ☐ Chest X-Ray Result
- ☐ N95 Fit Test Record
- ☐ Varicella Vaccine Dates/Titer Results
- ☐ Hepatitis B Vaccine Dates/Titer Results
- ☐ Tetanus/Diphtheria/Pertussis (Tdap)
- ☐ Seasonal Flu Vaccine
- ☐ MMR Vaccines or Immunization Record(s)/Titer Results
- ☐ Seasonal COVID Vaccine (if applicable)
- ☐ Lab Results (specify) _____
- ☐ Other* _____

** This form does not pertain to health screen documents or communications. It only pertains to vaccinations, titers, lab results, Chest X-Ray results, or Respiratory Protection documentation.*

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Any subsequent request will require a new Release of Information(ROI). The facility and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

This transmission is intended for the sole use of the individual and entity to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. You are hereby notified that any dissemination, distribution or duplication of this transmission by someone other than the intended addressee or its designated agent is strictly prohibited. If your receipt of this transmission is in error, please notify this firm immediately by replying to this transmission.

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I,_____ , agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

Caregiver Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____