

## **Release of Information: Caregiver Instructions**

1. Please complete the Release of Information Form
2. Email to [Caregiverhealthlubbock@providence.org](mailto:Caregiverhealthlubbock@providence.org)
3. You will receive them within 2 business days

# RELEASE OF INFORMATION

Caregiver ID: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Caregiver Information

*(If in GoFormz or OHM, type in ID. If not in OHM or GoFormz, type "NONE")*

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*Last First Middle (MM/DD/YYYY)*

Employed Caregiver  Volunteer  Non-Employed Provider  Agency  Other

Ministry: \_\_\_\_\_ Department: \_\_\_\_\_

Staff Type: \_\_\_\_\_ Job Title: \_\_\_\_\_

I would like to pick up the following information  Today  Another date (specify): \_\_\_\_\_

I would like the following information to be sent to my preferred email: \_\_\_\_\_

I would like the information mailed to:

Address: \_\_\_\_\_  
*Street Address Apt/Unit # City State Zip Code*

## Records

**Most Recent** or  **All**

- |   |   |
|---|---|
| <input type="checkbox"/> TB blood result                      | <input type="checkbox"/> Hepatitis B antibody titer           |
| <input type="checkbox"/> TB Questionnaire                     | <input type="checkbox"/> Hepatitis B immunization record(s)   |
| <input type="checkbox"/> Chest X-ray report                   | <input type="checkbox"/> Hepatitis A titer                    |
| <input type="checkbox"/> Measles-Mumps-Rubella (MMR) titer(s) | <input type="checkbox"/> Hepatitis A immunization record(s)   |
| <input type="checkbox"/> MMR immunization record(s)           | <input type="checkbox"/> Seasonal Flu immunization records(s) |
| <input type="checkbox"/> Chicken Pox (Varicella) titer(s)     | <input type="checkbox"/> N95 Fit Test                         |
| <input type="checkbox"/> Varicella immunization record(s)     | <input type="checkbox"/> PAPR/CAPR training record            |
| <input type="checkbox"/> Tdap/Td immunization record(s)       | <input type="checkbox"/> Pre-placement health screen          |

Other (specify): \_\_\_\_\_

**By signing this authorization, I am permitting release of this information by the method(s) indicated above in effect for one year unless terminated earlier in writing by the person giving the authorization**

### ELECTRONIC SIGNATURE ACKNOWLEDGMENT 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CHS OFFICE USE ONLY

Records released by: \_\_\_\_\_

CHS Location: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notes and Comments: