Employee Information

(Please Write Legibly):

Name:	
Address:	
Phone Number:	
E-Mail Address:	
Date of Birth:	

Nature of Treatment or Service:

The treatment or service provided under this authorization and consent shall include the following: COVID-19 Nasal swab testing ("the Service").

Consent to Service:

I, the undersigned, agree and acknowledge that I have been apprised of the risks of receiving the Service and that I knowingly and voluntarily consent to receiving the Service from Mobile-Med Work Health Solutions, Inc.

_____ _____

Signed Dated

Acknowledgment of Notice of Privacy Practices

I, the undersigned, agree and acknowledge that I have been offered a copy of the current Notice of Privacy Practices utilized by Mobile-Med Work Health Solutions, Inc.

_____ _____

Signed Dated

Consent for Disclosure of Protected Health Information

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

As Required by Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 160, 164

I, the undersigned, hereby authorize Mobile-Med Work Health Solutions, Inc. to use and/or disclose the protected health information described below to _____ ("Employer").

This authorization covers only the disclosure of results from the Services described above, which were conducted on this date and the results of which are anticipated to be received within thirty (30) days. I hereby authorize the release of protected health information consisting of the notice that I have received the Services, as well as the results of the testing included in the Services. I also consent to the release of any information required to bill for the services, as may be required by Employer, or by any health insurance plan or program that I am a part of. In addition, I understand that the results of any testing which demonstrates that I may have a

communicable illness may be reported to public health authorities in accordance with HIPAA regulations.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, determination about my ability to safely work or return to work, or other purposes that I may direct.
This authorization shall remain in effect for a period of one year, at which time this authorization expires.

I am **not** authorizing the release of mental health or psychotherapy records, alcohol or drug testing records or HIV test results.

I understand that I have right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my receipt of the services will be conditioned on whether I sign this document, as the care referenced above is being provided solely for the purpose of providing protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I, the undersigned, agree and acknowledge to the disclosure of Protected Health Information as described above.

_____ _____

Signed Dated