Release of medical information to employer

Employee/Patient Full Legal Name: _____

Date of Birth: _____ SSN# __ __ __ - __ __ - __ __ __ __ Sex: ____ Male ___Female

Home Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Employer Name: _____

**** By signing below, you agree that you have read the following statement and consent ****

I authorize MyHealth Urgent Care, and its associates to perform services and/or tests related to and authorized by me as an individual, employer, school, court or other authorizing agency. I authorize the release of any records, or other information to my employer, insurance carrier, or any other agent for whom these services are being authorized. I understand if services are found not authorized I will be responsible for payment of services related to this service. I give my consent and permission to MyHealth Urgent Care to obtain a specimen to be analyzed for COVID-19 Testing. I understand and authorize the result of this testing will be disclosed to the employer requesting the services. Disclosure and use of results, information or any other private information will be limited in accordance with applicable laws covering confidentiality of records. I understand I have the right to refuse services and the employer authorizing and requesting such services can and will be notified. The signature below acknowledges this statement and if I am requested to provide a specimen for COVID-19 Testing, I understand the specimen I am providing is my own. I understand that MyHealth Urgent Care and its associates retain the right to refuse services to any individual not complying with State or Federal Laws and Regulation. I understand that MyHealth Urgent Care is not responsible for employment outcomes based on COVID-19 Testing.

Signature: _____ **Today's Date:** _____