CARE STAFFING
Professionals

Authorization for Use Disclosure of Health Information

I authorize the use or disclosure of my health information as described below.

1. Person(s) or class of persons authorized to use or disclose the information: (Note: e.g. Name of Provider, lab, etc. that will disclose the information)

   Please List: _____

2. Person(s) or class of persons authorized to receive the information:

   CARE STAFFING PROFESSONALS, Inc. **and its authorized employees only**

3. Description of information that may be used or disclosed: (Note: e.g. all information related to a specific test or type of evaluation)

   Please List: _____

4. The information will be used or disclosed for the following purposes:
   For use by ***CARE STAFFING PROFESSONALS, Inc.*** and its clients in evaluating my qualifications for employment opportunities and related activities.

5. I understand that if the person or entity that receive the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization at any time by sending a written request to the party identified in paragraph 1, except to the extent that action has been taken in reliance on this authorization.

7. This authorization expires _____[Please insert a date or described the termination of an event or activity related to the individual or to the purpose of the authorization. This date relates to the termination of the right to the provider to disclose the information and not to ***CARE STAFFING PROFESSONALS, Inc.*** right to use this information, which, once the information is disclosed, does not terminate].

I acknowledge, understood and accept this Agreement/Statement.

_____ _____

Signature **Date**

_____ _____

Name