Medical Staffing Solutions

"The *Solution* to your Staffing Needs"

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:
   Medical Staffing Solutions, LLC or it's divisions.

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 Medical Staffing Solutions and its clients in evaluating my qualifications for employment opportunities and related activities.

5. I understand that if the person or entity that receives 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 describe 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 for the provider to disclose the information and not to Medical Staffing Solution's right to use this information, which, once the information is disclosed, does not terminate].*

Signature of Patient or Representative

Date

Patient Name

Name of Personal Representative (if applicable)

Relationship to Patient

(A copy of this signed form will be provided to the patient)