HIPAA Authorization to Release Medical Information

Employee name: _____

Program: _____

In the event that I am positively diagnosed with COVID-19, I hereby authorize a designated representative of St. Clair County Community Mental Health Authority to release information relating to: my identity, date of positive COVID-19 diagnosis, history of location(s) recently worked, known individuals with whom I have had contact

This information may be released to: potentially exposed co-worker(s) and potentially exposed person(s) served and other identified potentially exposed individuals

For the purposes of: notification of exposure, need to self-quarantine and monitor for symptoms, community health and safety

Release effective date: _____ Release expiration date: _____

- I understand the potential that information disclosed under this authorization may be redisclosed by the recipient and no longer is then protected by the Privacy Rule.
- I understand that I may refuse to sign this authorization and that generally my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.
- I understand that I may inspect and/or obtain a copy of any information used/disclosed under this authorization.
- I understand that I may revoke this authorization at any time by notifying St. Clair County Community Mental Health in writing, but I understand that previously disclosed information would not be subject to my revocation request.

_____ _____

Employee Signature Date

_____

Employee Printed Name

_____ _____

Witness Signature Date

Original: Human Resources
Copy to be given to the employee providing authorization