Holsman Healthcare, LLC
Healthcare Staffing and Consulting Services
Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

Authorization for Release of Medical & Personnel Records

To request the release of personnel, medical, or protected health information (PHI) records, please complete, sign, and return this form to the Quality Assurance Department; Holsman Healthcare; 710 Mill St. Unit H3; Belleville, NJ 07109. You may submit this form via fax to 973-759-0557. If you need help completing this form, please contact the Quality Assurance Department at 973-393-5545.

Employee Information

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Contact Phone Number: _____ ☐Home ☐Cell ☐Work

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Employee Status: ☐ Currently Assigned ☐ Not Assigned

I hereby authorize disclosure of my personal information as follows (Check all that apply):

- ☐ Copy of Licensure (specify state: _____)
- ☐ Copy of certification (select or specify: BLS ACLS PALS NRP _____)
- ☐ Reference / Evaluation (specify date (m/d/y): _____/_____/_____)
- ☐ Current or Most Recent Physical Examination (specify date (m/d/y): _____/_____/_____)
- ☐ Current or Most Recent TB Screening / PPD (specify date (m/d/y): _____/_____/_____)
- ☐ Current or Most Recent TB Screening / CXR (specify date (m/d/y): _____/_____/_____)
- ☐ Immunization Record (select or specify: MMR Varicella HBV _____)
- ☐ Lab titer results (select: Mumps Rubella Rubeola Varicella HBV _____)

The purpose of this release of information is for:

- ☐ Transfer of Records to Another Agency
- ☐ Attorney
- ☐ Personal Use
- ☐ Other (describe: _____)

Release of information is to:

Name: _____

Organization / Entity: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Delivery: ☐ Mail ☐ Fax

I hereby authorize Holsman Healthcare, LLC to release any personal or medical information as requested above. This may include protected information unless otherwise excluded. I am aware that Holsman Healthcare cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Holsman Healthcare may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Holsman Healthcare has relied upon it. For example, if I cancel it after Holsman Healthcare has sent requested records, Holsman Healthcare will not retrieve those records.

_____ _____
Signature Date