STAY SAFE MN

[your organization's logo here]

# Authorization for Disclosure of Protected Health Information to Employer

## Patient Information

Patient name: _____

Patient date of birth: _____

Phone number: _____

Medical record number: _____

## Release Information

Release Information From:
(*name of individual*)

_____

Release Information To:

_____

## Purpose of Release

This authorization will allow [clinic name] to work with [employer name] to discuss and coordinate my care for COVID-19 testing and recovery.

# Information to be Released

## Medical Information

Any lab test results relating to COVID-19 screening, including back to work recommendations.

## Service Dates

Any visits from the date I sign this form and one year forward.

# Expiration/Effective Dates

This consent will expire one year from the date I sign it. This authorization applies to any lab tests results related to COVID-19 screening after the date of my signature.

I may revoke this consent at any time by sending written notice to the [clinic name]. I understand this consent is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

Signature: _____

Date signed (required):_____

Time signed (required):_____

Relationship, if not patient: _____

*[Template provided by the Minnesota Department of Health (MDH). MDH cannot give any legal advice to your organization. For definitive legal advice, we recommend you contact your legal counsel. Delete this information before using. Call 651-201-5414 with questions]*