

Authority to Release Health Information

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

1. The information will be used or disclosed for the following purposes:

For use by Advantage RN and its clients in evaluating my qualifications for employment opportunities and related activities.

2. 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.
3. 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.
4. This authorization expires 1 year from date of signature below. *(This date relates to the termination of the right for the provider to disclose the information and to Advantage RN'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.)

Copy to Recruiter

Copy to Employee

Copy to Employee File

Advantage RN Corporate • 8892 Beckett Road • West Chester, OH 45069 • 866-301-4045 (phone) • 866-850-4048 (fax)
www.advantagern.com