Medical Records Request Form

Name: *

Date: *

Date of Birth: *

I authorize Ronara Staffing Solutions to release health information for the above named individual as described below:

Delivery Method: *

- [ ] USPS Mail
- [ ] Email

Items requested: *

- [ ] Physical
- [ ] Drug Screen
- [ ] TB Results
- [ ] Titers
- [ ] Fit Test
- [ ] Chest X Ray
- [ ] Immunization Record

Cost: *

- [ ] Medical Records: $55

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Compliance Department. I also understand that the revocation will not apply to information that has already been released.

I understand that once the above information is disclosed, it may be redisclosed by the receipient and the information may not be protected by ferderal privacy laws or regulations.

I understand authorizing use or releae of the information identified above is voluntary.

Signature: *