QCI Healthcare

Grand Rapids Office
2805 Coit NE
Grand Rapids, MI 49505
Phone: 616-365-9290
Fax: 616-365-9254

Livonia Office
32401 8 Mile Rd.
Livonia, MI 48152
Phone: 248-888-9030
Fax: 248-888-9003

Lansing Office
115 W. Allegan Ave. Suite 700
Lansing, MI 48933
Phone: 517-679-2670
Fax: 616-365-9254

Kalamazoo Office
5955 West Main
Kalamazoo, MI 49009
Phone: 269-353-3327
Fax: 616-365-9254

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider

_____ (Physician name) to use or disclose my health information during the termof this Authorization to the recipient(s) that I have identified below.

Recipient: I, _____ authorize my health care information to be released to the following recipient(s):

QCI Healthcare • 2805 Coit NE, Grand Rapids, MI, 49505 • Phone: (616) 365-9290 • Fax: (616) 365-9254

Purpose: I authorize the release of my health information to QCI Healthcare as a requirement for employment.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box)

- ❑ Physical (Fit to Work Letter) - within the last 365 days of this request
- ❑ TB Skin Test - within the last 365 days of this request
- ❑ Drug Screening – within the last 30 days of this request
- ❑ Covid-19 Test Results - within the last 30 days of this request
- ❑ OTHER:_____

Term: I understand that this Authorization will remain in effect until the provider fulfills this request OR 30 days after the quest date.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the QCI Chief Nursing Officer at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Employee Signature _____ Date _____ DOB_____

QCI Representative Signature_____Date_____