Comprehensive Health Services

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM IDENTIFIES AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, & PERSONS TO WHOM WE MAY MAKE THE DISCLOSURE:

- Comprehensive Health Services, Inc. (CHSi) and any associated officials, officers, directors, employees, agents, servants, consultants, affiliates or independent contracted medical clinics supporting the Wildland Firefighter contract are authorized to use and disclose Protected Health Information (PHI) and exam information (as described herein) to personnel of entities with which CHSi may contract for services (some of which services may be provided by you) in accordance with and as otherwise described in this authorization and the CHSi Notice of Privacy Practices.

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

- The information that may be disclosed is PHI and exam information collected as part of the Wildland Firefighter contract or prior contracts.
- PHI and exam information may include information regarding my medical exam including, but not limited to, physical exam, medical history, fitness testing, lab results, vaccinations, drug abuse, alcoholism or alcohol abuse, psychotherapy, psychiatric or mental illness, Hepatitis A, B, or C, Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV) regulated by Federal Statute (42 CFR Part 2).

PURPOSE OF THE USE OR DISCLOSURE:

- PHI and exam information may be used for medical screening, treatment, or fitness for duty assessments.

VALIDITY OF AUTHORIZATION FORM:

- This authorization will not expire until otherwise notified by you or upon contract termination, whichever occurs soonest.
- All PHI collected by CHSi is protected by the Privacy Act of 1974 (as amended), the Health Insurance Portability and Accountability Act of 1996 (as amended) and applicable state law.

ACKNOWLEDGMENT:

- I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.
- I understand that I have the right to revoke authorization; and that written notification addressed to the following party is necessary to revoke authorization:

  Comprehensive Health Services, Inc.
  8810 Astronaut Blvd.
  Cape Canaveral, FL 32920
  Attn: Wildland Firefighter Exam Operations

  I am aware that my revocation will not be effective as to disclosures already made in reference to this authorization.
- I understand that signing this authorization is voluntary and that CHSi will not condition treatment, payment or eligibility on the provision of this authorization. However, I also understand that voluntary failure to furnish the requested information may result in an inability to consider my application for

employment, determine if I meet the medical requirements to perform work duties, or participate within the screening program.

- I understand that any examination provided to me is NOT intended to provide or recommend diagnosis or treatment, and it is NOT a substitute for a periodic examination by my own personal healthcare provider who may test for medical conditions not included in this examination.

IF YOU HAVE ANY QUESTIONS ABOUT THIS AUTHORIZATION, PLEASE CONTACT COMPREHENSIVE HEALTH SERVICES, INC's PRIVACY OFFICER AT 800-638-8083.

CHECK, SIGN AND DATE:

☐ I authorize the use and disclosure of my protected health information and exam information as outlined herein.

_____ XX-XX-_____

Name Last 4 of Social Security Number

_____ ____/____/____

Signature Date