Authorization for Release of Confidential Medical Records

By signing this document, I,____, authorize Blue Med Consultants, LLC to release my COVID-19 test results to____.

I acknowledge the following statements:

1. I understand that I may revoke this authorization at any time by sending a written request to Blue Med Consultants, LLC. Such revocation will not have any effect on any action taken by Blue Med Consultants, LLC before the revocation
2. This authorization will expire 6 months from date of signature.
3. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
4. I understand that records in an electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of Blue Med Consultants, LLC or the person making the request. By requesting records in this format the requestor is knowingly and voluntarily assuming this risk and all consequences, losses, and damages that might result.

Signature:___________________________________

Date:_______________________________________