



Advanced Care Providers

Disclosure and Release

In connection with my application for consideration of staffing assignments (including contract for services) with Advanced Care Providers, I understand that a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes will be conducted. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas:

Verification of social security number; current and previous residences; employment history including personnel files; education including transcripts; character references; criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; birth records; motor vehicle records to include traffic citations and registration; and any other public records or to conduct interviews with third parties relative to my character, general reputation, or work ethics and performance.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to Advanced Care Providers or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release Advanced Care Providers, the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below.

I hereby authorize procurement of consumer report(s)/investigative consumer report(s). I understand this authorization automatically expires 90 days from the date executed below. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for Advanced Care Providers to procure consumer report(s)/investigative consumer report(s) at any time during my employment (or contract) period and to provide information to medical facilities I currently am credentialed at or facilities I agree to apply for credentialing and privileges. I understand I have the right to revoke the authorization at any time, provided I do so in writing.

Print Name:

Signature:

Date:



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Health Information Privacy & Consent Confidentiality Statement

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personally identifiable healthcare records came under a new and heightened level of confidentiality. In the regular course of business, Advanced Care Providers interacts and communicates directly with candidates who may share their personally identifiable information. In turn, we collect, store and process the information electronically and/or manually. With the belief that it is a person's right to have their personal information kept private, Advanced Care Providers conducts business with respect for and in compliance with all applicable health information privacy laws, including but not limited to HIPAA. We respect our legal obligation to implement privacy procedures and technical security measures to keep your personal information private and secure. As we are obligated to give you notice of our privacy practices, the statement of policies and protocols which follows describes how our staff may use and disclose your medical information and how you may get access to this information and relative accounting. After reviewing the information carefully, please complete, sign, and date this form, then return it via fax or mail to the addresses listed at the end of this statement.

For the purpose of this document and for employment through Advanced Care Providers, your "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's or health record statement
- Documentation used to prove immunity to measles, mumps, and rubella [laboratory titers or records of MMR injection(s)]
- Documentation used to prove immunity to varicella [laboratory titer, record of Varivax immunization, or immune by history statement]
- Documentation used to prove immunity to HBV [laboratory titer or record of HBV immunization series] or a declination statement thereof
- Annual tuberculosis screening [PPD test results or chest x-ray reading]
- Pre-placement drug screening [conducted by Advanced Care Providers or contracted facility]

Generally, we cannot use your health information or disclose it outside of our office without your written permission. The written permission comes from your completed consent form. We ask you to sign the consent form allowing us to use and disclose your health information for purposes of submittal to client facilities, of assignment to job openings at client facilities, and continued employment through Advanced Care Providers at client facilities. For example, your health information may be sent via fax or email to a client representative either for submittal consideration or to confirm placement. Facility representatives [HR managers, nursing officers, unit managers or medical staff services] will review your health information to evaluate whether or not you meet their standard immunization requirements set forth for temporary staff. An Advanced Care Providers representative will advise you of any necessary medical documentation for placement. Any variation from the facility standard may delay or cancel an assignment. We may refuse to place you if you do not sign the consent form. At times, client facilities may request further documentation than the above defined "health information" of a candidate's health and immunization records to comply with state or local regulations. At those instances, an Advanced Care Providers representative will advise you of the requirements and request your consent for that additional information.

The law gives you many rights regarding your health information. You may request photocopies of your health information, an amendment to any incorrect or incomplete information, additional copies of this notice, or a list of the disclosures we have made of your health information. Advanced Care Providers reserves the right to change this statement at any time in compliance with and as allowed by law. If we make any changes, the new policies and protocols will apply to your health information that we already have as well as to such information that we may generate or request in the future. We will send out notices of any changes via mail and post them in our office and on our website www.ACPstaff.com. If you should have any questions concerning Advanced Care Providers' privacy practices or wish to access or correct private information collected from you, please contact our HIPAA Privacy Officer via mail, phone, fax, or email: MAIL: PO Box 972, Minocqua, WI 54548 PHONE: 715-661-0030 FAX: 323-375-3290 EMAIL: mike@ACPstaff.com

I confirm that I have read, understand, and consent to the policies and protocols regarding disclosure and transmission of information as outlined in this statement regarding my health information.

Print Name:

Signature:

Date: