Medical Release Information

HIPPA Release Form

Name:____ Date of birth: __/__/__

I give permission to Public Health and/or Searhc Medical Center to release the following information to Craig Tribal Association's Covid Care Coordinator;

[ ] Documentation of being tested for COVID-19.

[ ] Documentation of a positive COVID-19 test.

[ ] Documentation of having to quarantine because of possible close contact.

This information can be sent faxed to 907-826-3996

I ____________________ understand that this information given to the Craig Tribal Association is purely for grant documentation. This information will remain with the Craig Tribal Association's Covid Care Coordinator.

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Occupant printed name and signature **Date**