



Holsman Healthcare, LLC  
Healthcare Staffing and Consulting Services  
Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

## 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, Holsman Healthcare 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, Holsman Healthcare 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 Holsman Healthcare, your "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's 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-employment drug screening [conducted by Holsman Healthcare]

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 Holsman Healthcare 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, or unit managers] will review your health information to evaluate whether or not you meet their standard immunization requirements set forth for temporary staff. A Holsman Healthcare 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, a Holsman Healthcare 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. Holsman Healthcare 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.holsmanhealthcare.com](http://www.holsmanhealthcare.com)). If you should have any questions concerning Holsman Healthcare's 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: 710 Mill St. Unit H3 Belleville, NJ 07109  
PHONE: 877-8268-9100  
FAX: 973-759-0557  
EMAIL: [richard@holsmanhealthcare.com](mailto:richard@holsmanhealthcare.com)

By my signature below, 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_