Patient Consent for Use and Disclosure to Cert.Health

Health Care Provider Name :

I hereby give my consent for the Health Care Provider named in this Consent to disclose protected health information (PHI) about me to Cert.Health (https://cert.health) for purposes of issuing a digital certificate (credential) for my benefit. The subject of said credential is an (check which applies):

☐ Immunization or

☐ Test

performed by the Health Care Provider on ________________________________ (date of test or immunization).

The Privacy Policy provided by Cert.Health (https://cert.health/privacy) describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. I hereby acknowledge that I have by read and accept the term of the Cert.Health Privacy Policy.

By signing this form, I am consenting to allow the Health Care Provider to use and disclose my PHI to Cert.Health. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian	**Print Patient’s Name**

Print Name of Patient or Legal Guardian, if applicable