Reporting Health Care Provider: ____________________
Laboratory: ____________________
Address: ____________________
Phone Number ____________________

Receiving Entity: ____________________
Address: ____________________
Phone Number: ____________________

Receiving Public Health Department: City and County of San Francisco Department of Public Health
Address: Schools-childcaresites@sfdph.org
Phone Number: 628-217-7499

Purpose of Disclosure:

I authorize ____________________ its agents, and contractors to disclose my individually identifiable health information related to COVID-19 testing and results as described below. I specifically authorize ____________________, its agents, and contractors to communicate information by any reasonable means, including written or telephone communication or by direct interview, whether or not I am present during or notified of such communication directly to ____________________ its agents, and contractors. I understand that the information I authorize to be disclosed may no longer be protected by federal privacy regulations.

I authorize ____________________ to disclose my test results for COVID-19 to ____________________ for the purpose of the school informing me of my test results and answering medical questions related to those results.

I authorize ____________________ to disclose my (employee/agents) test results for COVID-19 to ____________________ for the purpose of me being cleared to participate in the face-to-face instructional period on campus at ____________________

I understand and agree that my test will be processed by ____________________ and that ____________________ will provide the results to ____________________ and inform City and County of San Francisco Department of Public Health of the results of my test for public health purposes.

I understand and agree that ____________________ will communicate my test results to me.

I agree to learn of my COVID-19 test results by phone. I agree that this information may be left via

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voicemail, if I am unavailable when contacted via phone.

I understand and agree that if my test is positive for COVID-19, the City and County of San Francisco Department of Public Health will follow up with me and people I have been in contact with to discuss necessary steps for stopping further spread of the virus.

Voluntary Nature of Disclosure

I understand that I am not required to agree to this disclosure. I understand that a refusal to disclose this information will not affect my employment status or my student status, as applicable.

Confidentiality is Not Guaranteed

My test results are my confidential medical information. Circumstances may require identifying me as an individual who tested positive for COVID-19, in order to appropriately warn those others so they can take the necessary steps and precautions related to potential exposure to COVID-19. If an effective public health communication can be made without identifying me, my name will not be used. However, I understand that it may not be possible to inform others of a potential exposure to COVID-19 without them determining that it was through contact with me.

Effective Immediately

My consent and authorization for this disclosure is effective immediately. My consent and authorization may be revoked by me by contacting ______________________________. This revocation will become effective only upon receipt.

Unless previously revoked, this authorization will terminate one year after the date of my signing.

I have been advised that I have a right to receive a copy of this authorization.

____ ________________

Signature of employee or student Todays Date

____ ________________

Printed name Phone Number

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