Northwestern Medicine®

COVID-19 TESTING AND DIAGNOSTIC SERVICES FOR EMPLOYEES

Employee Name: _____ **Date of Birth:** _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Northwestern Memorial HealthCare and its clinical affiliates or an independent laboratory acting on their behalf (collectively "NMHC") to **disclose my identifiable health information related to my COVID-19 testing and diagnosis to My Employer**. The purpose of the disclosure is to assist **My Employer** in accessing and evaluating my COVID-19 results for follow-up purposes, including quarantine, exposure evaluation, and contact tracing.

My Employer has requested that NMHC provide testing and diagnosis for COVID-19 to me so that the information may be shared with **My Employer**. NMHC may not condition my testing, diagnosis or treatment on signing this authorization. I also understand that once NMHC releases my identifiable health information, federal and state privacy laws may not protect the information, and the entity receiving my information may re-disclose it.

This Authorization to Release Information will be valid for four years from the date of my signature. If I change my mind and no longer wish for my identifiable health information related to my COVID-19 testing and diagnosis to be shared with **My Employer**, I must let NMHC know in writing by contacting the NMHC Medical Records Department (contact information set forth below). NMHC clinical affiliates will then no longer share my identifiable health information related to my COVID-19 testing and diagnosis with **My Employer** (although NMHC will not be able to take back any disclosures that it made while this authorization was in effect), and NMHC may inform **My Employer** of such election.

_____

Patient or Patient's Legal Representative Signature

Date:_____

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