AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS

I give Kittitas Valley Healthcare permission to release SARS COV 2 (Covid019) test results to:

☐ Cle Elum Roslyn School District ☐ Easton School District ☐ Ellensburg Christian School

☐ Ellensburg Developmental Preschool ☐ Ellensburg High School ☐ Kittitas School District

☐ Lincoln Elementary School ☐ Morgan Middle School ☐ Mt. Stuart Elementary School

☐ Thorp School District ☐ Valley View Elementary School ☐ Other _____

The records of:

Patient Name:_____Other Names: _____

Date of Birth:_____ Phone: _____

Reason for release of records:

☐Other: School Policy

I understand that KVH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

_____ _____ _____

Signature of Patient OR Legally Responsible party **Relationship** **DATE**

This authorization expires 90 days from the date signed or on the following day/event:

ONE COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT

AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS

9/25/2020

PATIENT NAME:

DOB:

FIN: