AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ________________________________, whose date of birth is ________________________, as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to the extent applicable, hereby authorize ATC HEALTHCARE TESTING AND SCREENING SERVICES, LLC ("ATC"), and any COVID-19 testing provider that under an agreement with ATC provides COVID-19 testing services, to test me for COVID-19 using a swab test, antibody test or other COVID-19 test, and to disclose my COVID-19 test results and/or symptom results to my employer or educational institution, who is an Authorized Recipient as provided herein, which disclosure may be made by email transmission or by providing access through an internet portal to a database. I deem such disclosure to be necessary to aid in stemming the spread of COVID19 at my workplace, school and in the community.

1. Authorized Tester. This Authorization shall extend to ATC and any COVID-19 testing provider that under an agreement with ATC provides COVID-19 testing services and that has protected health information as defined in the Standards for Privacy of Individually Identifiable Health Information issued by the U.S. Department of Health and Human Services to implement the privacy requirements of HIPAA (the "Privacy Rule"). Each such person or entity is referred to herein as an "Authorized Tester".

2. Available Protected Health Information. The information that may be disclosed pursuant to this Authorization (referred to herein as my "Available Protected Health Information") is limited to my COVID-19 Test and COVID-19 Symptom Results.

3. Authorized Recipients. Each person authorized to receive any of my Available Protected Health Information as set forth herein below is referred to herein as an "Authorized Recipient".
a. An Authorized Tester is authorized to disclose all of my Available Protected Health Information in its possession to any of the following Authorized Recipients:
i. Name of Management Personnel designated as the recipient of COVID-19 Test and COVID-19 Symptom Results; b. Except as otherwise provided herein, an Authorized Recipient may execute any document that he or she deems appropriate and necessary to obtain my Available Protected Health Information pursuant to this Authorization. Likewise, an Authorized Tester may request that any person claiming to be an Authorized Recipient provide such Authorized Tester with such documentary evidence as is reasonable to confirm that such person is an Authorized Recipient. If an Authorized Tester unreasonably refuses to recognize and accept this Authorization, the Authorized Recipient seeking to obtain my Available Protected Health Information from such Authorized Tester pursuant to this Authorization may initiate any necessary legal action to compel disclosure of such information and may seek to recover from the Authorized Tester any legal fees and costs incurred thereby.

4. Termination and Revocation. I may revoke this Authorization at any time by a writing delivered to any person or entity in possession of this Authorization. Revocation of this Authorization as it applies to an Authorized Tester shall be effective upon the Authorized

Tester's receipt of my written revocation except to the extent that the Authorized Tester has taken action in reliance on this Authorization. Receipt of a written revocation may be evidenced by any reasonable method of confirmed delivery. This Authorization shall terminate on the two (2) year anniversary of my death if not previously revoked by me or my personal representative (as defined in the Privacy Rule).

5. Re-Disclosure. By signing this Authorization, I acknowledge that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the Authorized Recipient in receipt of such information and may not be protected by HIPAA or the Privacy Rule. No Authorized Tester shall require an Authorized Recipient to indemnify the Authorized Tester or agree to perform any act in order for the Authorized Tester to comply with this Authorization.

6. Right to Treatment. I understand and hereby acknowledge that no Authorized Tester may condition my receipt of health care upon my execution of this Authorization. Nothing herein shall be deemed to make any Authorized Tester responsible for my health care and no Authorized Tester will have any responsibility for my health care except as otherwise expressly agreed by the Authorized Tester and me. I acknowledge that I have the right to refuse to sign this Authorization if I wish to do so.

7. Waiver and Release. Except as otherwise provided herein, no Authorized Tester shall be liable for disclosing my Available Protected Health Information in reliance upon and in compliance with this Authorization nor shall an Authorized Tester be liable for any action taken by any Authorized Recipient.

8. Acceptance of Copies. Any photostatic, xerographic, facsimile or other electronic copy of this duly executed Authorization shall be as effective as the original. IN WITNESS WHEREOF, I have hereunto signed my name on (date) .

Printed Name____

Signature____

Phone Number____

ATC COVID-19 Testing Consent

Authorizing Provider: Robert Van Amerongen MD	Testing Site: Baldwin Union Free School District
X Nasopharyngeal ◯ Oral ◯ Mid-turbinate Type of Test: Swab	Lab Assigned: Genesis

Minor's Information	
Minor's Name (Last, First Middle)	Minor's DOB (MM/DD/YYYY)
Preferred Parent/Guardian Phone Number	Minor's Address

I authorize that a test sample be taken for COVID-19 as ordered by the authorizing provider (or my child's or legal dependent's physician or authorized healthcare provider). I do hereby consent to any physician or health care provider or authorized provider examining or testing my minor child to use or disclose protected health information for reporting purposes.

SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILD UNDER 18

I,____, have the following relationship with the person above:

◯ Father ◯ Mother ◯ Stepfather ◯ Stepmother ◯ Court ordered legal guardian
◯ Grandfather ◯ Grandmother ◯ Adult Aunt ◯ Adult Uncle ◯ Adult Brother ◯ Adult Sister

I have the legal authority, based on the relationship to the child as indicated above pursuant to New York Public Health Law § 2504, to consent to this test administration for the child named above.

Parent or Guardian Signature	Date