AUTHORIZATION TO USE AND EXCHANGE COVID-19 INFORMATION

ALL LINE ITEMS MUST BE COMPLETED & RETURNED TO SCHOOL NURSE/DAYCARE ADMINISTRATION

Name of Staff or Student/Attendee _____
(FULL PRINTED NAME)

Name of Parent/Guardian _____ School/Daycare Name_____

I am authorizing that in the event I (staff) have / my child (student/attendee) has COVID-19, the following confidential information may be exchanged:

- ✓ My name and school/daycare
- ✓ COVID-19 test result, date of test, and date of illness
- ✓ Date of birth _____
- ✓ Home address _____
- ✓ County or City in which I live _____
- ✓ Phone number(s) _____ (for Health Dept. to reach you)
- ✓ Email address(es) _____ (for Health Dept. to reach you)

I request that School/Daycare Administration and the following entities be able to use and exchange this information among themselves for public health purposes:

- ✓ Alexandria Health Department
- ✓ My Local Health Department (based on home residence)
- ✓ Testing Provider (Doctor or Hospital)

CHECK ONE:

- ❑ **I authorize** the release of the information above as it pertains to a COVID-19 diagnosis, in order to facilitate COVID-19 contact investigations and related safety/infection control responses performed at my school/daycare, with the understanding that my/my child's personal information and protected health information will not be disclosed to parties not directly involved with the public health investigation. I understand that I have the right to revoke this authorization in writing at any future date.

- ❑ **I <u>do not</u> authorize** the release of the information above as it pertains to a COVID-19 diagnosis, in order to facilitate COVID-19 contact investigations and related safety/infection control responses performed at my school/daycare. I understand that I can revise this declination at any future date, and understand that with the authorization my/my child's personal information and protected health information will not be disclosed to parties not directly involved with the public health investigation.

Signature: _____ Date: _____

Full Printed Name: _____

PLEASE COMPLETE ENTIRELY

Incomplete Forms Will Delay the Future Public Health Response

Return completed forms to School Nurse / Daycare Administrator (or designee)

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