AUTHORIZATION TO CONDUCT COVID-19 DIAGNOSTIC TEST:

Patient Name: _____

Patient Address: _____City/State:_____ Zip Code: _____

Tele:_____

Date of Birth:_____

I authorize Westchester Medical Center to conduct a COVID-19 diagnostic nasopharyngeal test on the above named individual at:

Pelham Memorial School, 575 Colonial Avenue, Pelham, New York 10803

Purpose of Test: SCHOOL ATTENDANCE

This authorization will expire one year from the date on which it was signed if no expiration date or event is indicated below:

Please note desired expiration date or event, if any:_____

I have read this form and all of my questions have been answered to my satisfaction. By signing this form, I acknowledge that I have read and accept all of the above.

_____

Patient Signature/Signature of parent/guardian if patient is under age 18

_____

Print Name

_____

Relation to patient if patient is under age 18

_____

Date

WMC Health
Westchester Medical Center Health Network

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (COVID TEST RESULTS)

Patient Name: _____

Patient Address: _____ City/State: _____ Zip Code: _____

Date of Birth: _____ Tele: _____

I authorize Westchester Medical Center to disclose the above named individual's health information as follows:

Name and address of person(s)/entity to whom this information is to be sent ("Recipient"):

Name: PELHAM SCHOOL DISTRICT

Address: 575 Colonial Avenue, Pelham, New York 10803

Description of Information to be disclosed: COVID-19 DIAGNOSTIC TEST RESULTS ("**COVID Information**")

Purpose of Disclosure: SCHOOL ATTENDANCE

This authorization will expire one year from the date on which it was signed if no expiration date or event is indicated below: *Please note desired expiration date or event, if any*: _____

This authorization permits the release of COVID Information of the above-named individual to the above-named Recipient on an ongoing basis, for however many COVID tests such individual undergoes before the expiration of this authorization.

1. I understand that any disclosure/release is bound by the Health Insurance Portability and accountability act of 1996 (HIPAA) 45 C.F.R. pts 160 & 164; and re-disclosure of this information to a party other than one designated above is forbidden without written authorization on my part.
2. Westchester Medical Center does not condition treatment or payment on your signing this authorization.
3. I understand that Westchester Medical Center has no ability to prevent re-disclosure of my COVID Information by Recipient.
4. I understand that I have a right to revoke this authorization at any time, except to the extent that Westchester Medical Center has already acted in reliance on it. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department of Westchester Medical Center, at 100 Woods Road, Macy Pavilion, Room M18, Valhalla, New York 10595 (Phone: 914-493-7600). I ALSO UNDERSTAND THAT REFUSAL TO SIGN, OR REVOCATION OF THIS AUTHORIZATION, MAY RESULT IN MY BEING PROHIBITED FROM ENTERING SCHOOL BUILDINGS OR SURROUNDING SCHOOL PREMISES.

I have read this form and all of my questions have been answered to my satisfaction. By signing this form, I acknowledge that I have read and accept all of the above.

_____

Patient Signature/Signature of parent/guardian if patient is under age 18

_____

Print Name

_____

Relation to patient if patient is under age 18

_____

Date