LOS ANGELES UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization describes how we may use and disclose your information to facilitate the Los Angeles Unified School District's ("LAUSD") COVID-19 testing and school community engagement program.

Completion of this document authorizes the disclosure and use of health information about you. Please provide all the information requested or this authorization may not be valid.

Authorization Required for Testing. I hereby authorize LAUSD to use and disclose the following information about the individual identified below (referred to as "I," "me," or "my" in this Authorization):

> All information that identifies me or that relates to testing me for exposure to the 2019 Novel Corona Virus (COVID-19) that is collected or created as a part of LAUSD's testing and school community engagement program, including without limitation my COVID-19 test results.

I authorize LAUSD to use and disclose the above information for any purpose related to LAUSD's COVID-19 testing and school community engagement program, including uses and disclosures required by law, disclosures to any county, state, or other government public health or other agency with jurisdiction, disclosures to LAUSD's contractors, vendors, and medical research partners for purposes of assisting in the design, development and operation of the testing program.

I further authorize LAUSD to disclose the above information for purposes of public health research for which individual information will not be published, for purposes of obtaining payment or reimbursement for testing and related services, or for purposes of notifying parents, teachers or other staff, or members of the public about school and community exposure and infection rates, which may include without limitation publication on LAUSD's website or through the news or other media, and which may be done in a manner which will not include my name, but from which my identity could potentially be determined.

Expiration. This Authorization will expire after a period of one (1) year.

I Understand My Rights. I understand that:

I may refuse to sign this Authorization;

Refusal to sign this authorization will not result in LAUSD's denial of any treatment for any health care condition or payment for health care that would otherwise be provided, or in LAUSD's denial of any otherwise existing eligibility or enrollment in any health benefit program;

I have the right to receive a copy of this Authorization;

I may revoke this authorization at any time, but I must do so in writing and send it to:

Los Angeles Unified School District
Office of Data and Accountability
333 South Beaudry Avenue, 16th Floor
Los Angeles, CA 90017

Re-Disclosure. I understand that information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by applicable law and may no longer be protected by federal confidentiality laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please print the Name of Individual for Whom This Authorization is Given (*e.g.*, name of student, employee or other person to be tested):

_____

__ Student __ Employee __ Other (Please describe): _____

_____

Signature of adult to be tested or parent/guardian of minor for whom authorization is being provided:

_____

Date: _____

If signed by other than the patient, indicate relationship and print name:

_____

Ed. 100220