

EMPLOYEE AUTHORIZATION TO DISCLOSE NAME AND COVID-19 DIAGNOSIS

I understand that the Americans with Disabilities Act and other privacy laws prohibit my employer (named above) from disclosing my medical/health information. In the interest of the health of my co-workers and others with whom I may have had contact with at the facility, I voluntarily authorize my employer to disclose to employees at my facility and to others (i.e., patients, visitors, etc.) whom I may have encountered at my facility or in connection with my employment, my name and that I have tested positive for the COVID-19 virus, that I have been exposed to the virus, or that I am experiencing principal symptoms of the virus. My employer has advised me that I am not required to give this authorization and that there would be no adverse consequences to my employment if I chose not to do so. Further, my employer did not seek to coerce or pressure me to authorize this disclosure.

Signature of Employee or Authorized Representative in the event of Employee's incapacity:

Date:

Employee or Authorized Representative Name and relationship to Employee (print):

SIGNING THIS AUTHORIZATION FORM IS VOLUNTARY