CDR|HEALTH

AUTHORIZATION FOR DISCLOSURE OF COVID-19 TEST RESULT

Patient Name: First/Middle/Last:	
Patient Date of Birth:	**Patient Facility Name:**
Patient/Facility Street Address:	
City:	**State:** **Zip:**
Patient Phone:	**Patient Email Address:**
I am the: ("Authorizing Individual"): ☐ **Patient** ☐ **Guardian** ☐ **Legally Authorized Representative**	

By completing and signing this Authorization for Disclosure of COVID-19 Test Results (the "Authorization"), I am hereby authorizing CDR Health Care Inc., ("CDR") to disclose and release to **Orange County and Orange County Human Resources Department**, my (or the patient above's) COVID-19 test results and name, date of birth, address and email information collected by CDR Health Care Inc., acting as an agent of Orange County, a subdivision of the State of Florida. In addition, I also understand (or acknowledge on behalf of patient above) that:

- This Authorization is effective immediately upon execution and that I may revoke this Authorization at any time by notifying CDR by email, at COVID19consents@cdrmhealth.com (using the subject line *Revocation of Authorization For Disclosure of COVID-19 Test Results*) except to the extent action has been taken in reliance on this Authorization.

- PHI released under this Authorization may no longer be protected by the state and federal privacy laws and may be redisclosed by those to which I authorize disclosure.

Signature of Authorizing Individual:

Date: