AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION BY 6M GERIATRICS & HOSPITAL MEDICINE PLLC

COVID-19 is extremely contagious. As a result, federal, state, and local governments and state and county health agencies have regulated activities, including recreation, team sports, and group gatherings.

I wish to take a COVID-19 test as a preventative measures to reduce the spread of COVID-19. I understand that I will not be allowed into _____ ("a Facility") unless (i) I agree to take a COVID-19 Test, (ii) the COVID-19 test result is negative, and (iii) the Facility is informed of the negative test result.

I, _____ (printed name), authorize: **6M GERIATRICS & HOSPITAL MEDICINE PLLC**, ("**6M Geriatri**c") to disclose the laboratory results of my COVID-19 test to the Facility.

What information may be disclosed?

- I authorize 6M Geriatric to provide the Facility with the results of my COVID-19 test, including my identifiable health information (e.g., name, address phone number, health care status, billing statements, description of health care services provided, diagnostic information, payment information, etc.) so that the Facility can better understand my exposure to COVID-19.

Who is disclosing and who is receiving, my protected health information?

6M GERIATRICS & HOSPITAL MEDICINE PLLC, its staff and employees, will disclose your identifiable health information to the Facility. If you wish to contact **6M GERIATRICS & HOSPITAL MEDICINE PLLC,** they can be reached at the following:

Address:	620 Terry Ave, Suite 202 Seattle Washington 98104
Telephone:	206-707-1665
Email:	admin@6mgeri.com

Can I revoke my authorization?

- You have the right to revoke this authorization. A revocation must be in writing. However, your revocation may not be effective if 6M Geriatric already took action in reliance of your authorization. If you wish to revoke the authorization, you should contact 6M Geriatric.

What if I refuse to sign this authorization?

- You have the right to refuse to sign this authorization. However, because 6M Geriatrics is performing your COIVID-19 test only to provide a test result and to disclose it to the Facility, if you do not consent to this authorization, 6M Geriatrics will not perform your COVID-19 test.

When will my authorization expire?

- This authorization will expire one year from the date this form is signed unless is revoke the authorization.

I AGREE AS FOLLOWS:

I have read and fully understand this authorization. I agree to the terms set forth in this authorization. I acknowledge that I have been provided with a copy of my signed authorization. I also understand that once the Facility receives my identifiable health information, it may be subject to re-disclosure by the Facility and my protected health information, may no longer be protected by applicable federal privacy laws.

I understand that this authorization may be executed through the use of an electronic signature, in accordance with the Electronic Signatures in Global and National Commerce Act (E-Sign Act), Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act (UETA), and any applicable state law, and that any electronic signature shall be deemed an original signature for purposes of this Authorization, with such electronic signature having the same legal effect as an original signature.

Name:	Mailing Address:
Date of Birth:	City/State/Zip:
Telephone number:	E-mail Address:
_____ Patient Signature	
_____ Patient Printed Name	_____ Date

OR, if applicable:

_____ Patient Representative Signature	_____ Relationship to Patient
_____ Patient Representative Printed Name	_____ Date