# COVID-19 TESTING AUTHORIZATION RELEASE

| PATIENT NAME: FIRST / MIDDLE / LAST | | | | DATE OF BIRTH |
|---|---|---|---|---|
| EMAIL ADDRESS | | | | ☐ NO EMAIL |
| STREET ADDRESS | CITY | STATE | ZIP | AREA CODE PHONE # |

I am the ☐ PATIENT ☐ GUARDIAN ☐ CONSERVATOR ☐ DESIGNEE and hereby authorize ☐ Natividad to use or disclose health information.

| PURPOSE: THE DISCLOSURE OF THESE RECORDS IS FOR THE FOLLOWING PURPOSE(S) ONLY |
|---|
| COVID-19 FOR PERSONAL USE / PROOF FOR EMPLOYMENT |
| DATES & TYPE OF INFORMATION TO BE DISCLOSED: |
| COVID-19 TEST RESULTS |

If you are the patient requesting your own records. Please check one:
☐ Email ☐ U.S. Mail ☐ Text

INFORMATION TO BE RELEASED: This is a full disclosure authorization of health care information related to COVID-19 testing only. Standard text messaging rates may apply.

Thank you for checking the status of your results.
Please complete this form.
Send an image of the completed form, along with
an image of your photo ID or other proof of ID.
To:
COVIDInfo@natividad.com

| DATE | PATIENT SIGNATURE | ☐ VERBAL CONSENT |
|---|---|---|
| | | |

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AUTH FOR USE/DISCLOSURE OF HEALTH INFO

AUTHRELINF

AUTHORIZATION TO USE OR DISCLOSE COVID-19 HEALTH INFORMATION

PATIENT LABEL