

**University of Richmond COVID-19 Screening and Testing
Authorization for Release of Testing and Screening Results Faculty and Staff**

I understand that the University of Richmond is encouraging faculty and staff members who will be working or teaching on campus during the fall of 2020 to be tested for SARS-CoV-2, the virus that causes COVID-19, at the start of the academic year and then, subsequently, as necessary to identify cases of COVID-19 within the University community.

I understand that the University of Richmond has contracted with SecureHealth to provide COVID-19 testing, among other services (“COVID-19 Services”).

I consent to allowing the University of Richmond to share the following information with SecureHealth and the laboratories engaged by Secure Health to perform COVID-19 testing on specimens collected by Secure Health, including LabCorp and NEXT Molecular Analytics, (the “Laboratories”):

- My name;
- My contact information, including but not limited to address, phone number, and email address;
- My date of birth;
- My employee ID number; and
- The fact that I have been referred for COVID-19 testing.

I agree and acknowledge that SecureHealth and the Laboratories will administer COVID-19 testing to me and will collect and/or have access to the following information:

- The results of my COVID-19 test; and
- Any symptoms of infection with COVID-19 (e.g., fever of or over 100°F, cough, shortness of breath, sore throat) that I exhibit as of the day of testing.

I further agree to notify SecureHealth if I have had contact with someone in the past 14 days with suspected or confirmed COVID-19.

I hereby authorize SecureHealth and the Laboratories to disclose the information listed above to University of Richmond.

I agree and acknowledge that the University of Richmond and/or its Human Resources Department may share the results of my COVID-19 test with other University or state or local health department officials for purposes of scheduling or managing my absence from work, arranging for my return to work, connecting me to support services, and tracking and containing COVID-19 cases on campus, including contact tracing.

I understand that I may revoke this Authorization in writing at any time and such revocation will be effective when delivered to the University of Richmond Human Resources Department, but will not apply to information that has already been released in response to this Authorization.

As the person signing this authorization, I understand that I am giving my permission to use or disclose my **confidential health** records as indicated above. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under applicable privacy laws.

This authorization will be valid until revoked by me.

I have read and understand the information in this Authorization form.

Signature

Print/Type First and Last Name

Date: _____

Employee ID#: _____

Date of Birth: _____

Cell Phone #: _____