AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ , authorize *Dr. Scott Miscovich and Premier Medical Group USA* to disclose the following to the **University of Mississippi and its affiliates**:

- health records related to any COVID-19 testing conducted on or after the date hereof, including any and all personal information collected in connection with such testing.

The purpose of the disclosure authorized herein is to **notify the University/Host of COVID-19 status in campus communities.**

I understand that to the extent my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164, this document authorizes the release of my records as indicated herein.

I further understand that for the purposes disclosed above, the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re- disclose the information and that re-disclosure may not be prohibited by the HIPAA privacy law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

- One year from signature date.

I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

Dated: _____ _____

(Signature of patient or authorized representative)

COVID-19 TESTING INFORMED CONSENT

i. I authorize Premier Medical Group to conduct collection and testing for COVID-19 through a Nasal PCR swab or blood draw, as ordered by an authorized medical provider.

ii. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I understand that Public Health authorities may contact directly should I test positive.

iii. I acknowledge that a positive test result is an indication that I must self-isolate in an effort to avoid infecting others.

iv. I understand the testing unit is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

v. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been informed that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Dated: _____ _____

(Signature of patient or authorized representative)