AUTHORIZATION FOR RELEASE OF COVID-19 TEST RESULTS

Patient Name:____

Student ID No: _________________________________

To: RIVERSIDE MEDICAL CLINIC (“**Healthcare Provider**”)

I am over the age of 18. I hereby authorize and direct the above-named Healthcare Provider to release my COVID-19 test results, diagnosis and treatment (collectively **“Test Results**”) to the following Designated Recipient:

California Baptist University (**“Designated Recipient**”)
Attn: Kent Dacus, VP for Enrollment and Student Services
Telephone: (951) 343-4355
E-Mail Address: kdacus@calbaptist.edu

The Designated Recipient has requested that Healthcare Provider test certain students for COVID-19; the Test Results will be used by Designated Recipient for the purpose of mitigating the spread of COVID-19 on the campus of California Baptist University.

This authorization is pursuant to the Confidentiality of Medical Information Act of 1980, and California Civil Codes, sections 56-56.37. The person signing this authorization has a right to receive a copy hereof, and a reproduced copy of this authorization shall be as valid as the original. This authorization applies to all Test Results both prior to, and after the date of signature. I understand this consent may be revoked in writing at any time with the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above-named Healthcare Provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days from the date of signing. To initiate revocation of this authorization, direct all correspondence to the Designated Recipient above.

An electronic or facsimile copy of this authorization shall be considered as effective and valid as the original.

Patient Signature: __________________________________ Date: ________________________

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Signature of Parent or Guardian (Required for students under the age of 18 years) Date