COVID-19 TESTING AND DIAGNOSIS AUTHORIZATION

TO RELEASE INFORMATION

Grainger County Schools

Student Name:_____Birth Date: _____

I authorize Winbigler Medical, PLLC and its clinical affiliates or an independent laboratory acting on theirbehalf to disclose identifiable health information related to COVID-19 testing and diagnosis to the school listed above. **The purpose of the disclosure is to assist my child's school in accessing and evaluating Covid-19 results for follow-up purposes, including quarantine, exposure evaluation, and contact tracing.**

Grainger County Schools has requested that Winbigler Medical provide testing and diagnosis for Covid-19 to your child so that the information may be shared with Grainger County Schools. I understand that my refusal to sign this form means that Winbigler Medical will not render such testing and diagnosis for Covid-19 on behalf of Grainger County Schools. I also understand that once Winbigler Medical releases my child's identifiable health information, federal and state privacy laws may not protect the information, and the entity receiving their information may re-disclose it.

This Authorization to Release Information will be valid for one year from the date of my signature. If Ichange my mind and no longer wish for my child's identifiable health information related to their COVID-19 testing and diagnosis to be shared with Grainger County Schools, I must let Winbigler Medical know in writing by contacting Winbigler Medical, PLLC (jennifer@winbiglermedical.com). Winbigler Medical clinical affiliates will then no longer share identifiable health information related to COVID-19 testing and diagnosis with my child's school (although Winbigler Medical will not be able to take back any disclosures that it made while this authorization was in effect), and Winbigler Medical may inform my child's school of such election.

Parent/Guardian Name: _____

Parent/Guardian Signature:_____

Date:_____

Phone Number _____

School Student Attends _____