



# AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS

**I give Kittitas Valley Healthcare permission to release SARS COV 2 (Covid019) test results to:**

- Cle Elum Roslyn School District       Easton School District       Ellensburg Christian School
- Ellensburg Developmental Preschool    Ellensburg High School       Kittitas School District
- Lincoln Elementary School       Morgan Middle School       Mt. Stuart Elementary School
- Thorp School District       Valley View Elementary School    Other \_\_\_\_\_

**The records of:**

Patient Name: \_\_\_\_\_ Other Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for release of records:**

Other: School Policy \_\_\_\_\_

I understand that KVH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

_____	_____	_____
<b>Signature of Patient OR Legally Responsible party</b>	<b>Relationship</b>	<b>DATE</b>

**This authorization expires 90 days from the date signed or on the following day/event:**

ONE COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT

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9/25/2020

PATIENT NAME:
DOB:
FIN: