

## AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS TO EMPLOYER

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I voluntarily submitted to a COVID-19 test, processed by Florida Laboratory Analysis, LLC, pursuant to the request by my Employer, named below.

I hereby authorize Florida Laboratory Analysis, LLC and its designated agents and representatives to release the results of all my COVID-19 tests, taken today or taken again in the future, to my employer. I understand that lab's duty to report results is to the employer only, and I will seek information about the results from my employer through information provided by Florida Laboratory Analysis, LLC.

I understand the scope of the report may include, but is not limited to, the following areas: my name, work location or division, date specimen taken, date of test and test result.

I understand that the information may or may not be subject to the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act, worker's compensation and/or other state or federal law. I also understand that in certain circumstances, an employer or laboratory may have an obligation under public health reporting of communicable diseases laws to report those test results to the public health agencies.

I hereby unconditionally release Florida Laboratory Analysis, LLC and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family or associates because of compliance with this authorization and authorization to release, including but not limited to decisions by my employer based on the test result that impact my ability to work, my compensation or need to quarantine or isolate. I also release Florida Laboratory Analysis, LLC from any liability related to inaccurate test results (including but not limited to false positives or false negatives). I understand that the test only detects certain levels of the virus in my system at the date the specimen is taken. The test result is not a definitive diagnosis.

I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

### **Please Print Clearly**

1. Employer Name: \_\_\_\_\_

2. Your Name: \_\_\_\_\_

2. Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_

3. Telephone Number \_\_\_\_\_

4. Address: \_\_\_\_\_

\_\_\_\_\_

**By signing below, you authorize the release of test results according to the terms above:**

Signature \_\_\_\_\_

Date \_\_\_\_\_