

Authorization for Release of Medical Information

I hereby authorize The Claremont Colleges Services' Student Health Services to disclose the results of my SARS-CoV-2 tests and related information to my employer and my employer's human resources staff as well as to the human resources staff of any of the seven Claremont Colleges at which I perform work.

My employer and my employer's human resources staff may use my SARS-CoV-2 test results for the purpose of determining whether I am eligible to come to and remain on the campus of any of the seven Claremont Colleges or The Claremont Colleges Services, to contact persons who may have been in contact with me while I may have been infectious (commonly known as "contact assessment"), and for other administrative purposes. My test results may also be reported to the Department of Public Health in the county my mailing address is located in, the California Department of Public Health and other federal, state, and local health authorities, as required by law.

This authorization will expire on May 31, 2023.

I have a right to receive a copy of this authorization if I request it.

I acknowledge that I have read and understood the above and agree to authorize the disclosure of my medical information as described herein.

Signature: _____

Name: _____

Employee/Contractor ID #: _____

Date: _____