HealthCap
RISK MANAGEMENT SERVICES

FACILITY LETTERHEAD

Consent for Disclosure of COVID-19 Diagnosis & Status

Resident Name**:** _____

I hereby authorize [Facility Name] to disclose resolution of my COVID-19 diagnosis. I understand [Facility Name] would like to disclose resolution of my COVID-19 diagnosis and status so that my fellow residents and staff will know I no longer require isolation precautions.

I understand that by agreeing to disclose my COVID-19 diagnosis and status, I am not agreeing to the disclosure of any other protected health information (PHI).

I understand that this authorization is voluntary.

I understand that once my COVID-19 diagnosis and status is disclosed, the facility can no longer ensure its privacy.

I agree to waive all claims against the facility for the disclosure of my COVID-19 diagnosis and status.

I understand that I may revoke this authorization at any time by notifying the facility in writing; however, it will not affect any actions taken before they received the revocation.

I understand that this authorization will expire on _ _/_ _/_ _ _ _ (DD/MM/YYYY)
(Not to exceed 2 years from date signed)

_____ _____
Signature of resident or resident's representative Date

Printed name of resident's representative: _____

Relationship/authority to act on part of individual: _____
Power of Attorney, Guardian, Executor, Court Order
or Legally Binding Request for Information

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