AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL INFORMATION

To: **Nobility Health Inc**. ("Healthcare Provider")

I am a visitor of Southwestern Law School and I authorize the Healthcare Provider to disclose the results of my COVID-19 diagnostic tests ("Test Results") to the School's Department of Human Resources ("Designated Recipient").

I authorize the Designated Recipient and other personnel at the School with a need to know to use my Test Results to determine whether I am eligible to remain on the campus and to help manage, control, and prevent the spread of COVID-19 within the School community. My Test Results may also be reported to the Los Angeles County Department of Public Health, California Department of Public Health, and other federal, state, and local health authorities, as required by law.

I understand that:

- I have a right to receive a copy of this authorization if I request it.
- An electronic copy, photocopy or facsimile of this authorization shall be valid as the original authorization.

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

_____ _____

Signature Date

_____

Print Name