



Oregon Health & Science University  
 Hospitals and Clinics  
 Health Information Services/  
 Medical Correspondence  
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ACCOUNT NO.  
 MED. REC. NO.  
 NAME  
 BIRTHDATE

## OHSU COVID-19 K-12 TESTING AUTHORIZATION FORM

This Authorization Form allows you to grant a third party access to the information listed below.

By signing below, I authorize Oregon Health & Science University to disclose my child's protected health information described below to the persons or entities listed in this form.

**I hereby authorize OHSU to release of the following protected health information:**

- My child's name, medical record number (MRN) and date of birth with a test collection kit, showing that my child is being tested for COVID-19.

**This information may be released to:**

- \_\_\_\_\_

**This information will be used for:**

- Coordinating COVID-19 testing for my child with their school as part of the Oregon Health Authorities' (OHA's) K-12 Student Screening Program.

**I also understand and agree to the following:**

- Under ORS 109.650, OHSU may release a 15-17 year old child's test results to their parent and/or legal personal representative.
- I may receive my child's test results through a telephone call and/or email.
- I may refuse to sign this authorization. Refusing to sign the authorization will not adversely affect my child's ability to receive health care services or reimbursement for services.
- I have the right to revoke this authorization at any time by doing so in writing to **k12covidtesting@ohsu.edu**.
- Revoking this authorization will not apply to the disclosures already made by OHSU during the time that my authorization was valid.
- Any information used or disclosed through this authorization may no longer be protected by privacy laws and may be re-disclosed by the person or organization receiving it.
- This authorization will remain in effect until the end of the OHA's K-12 Student Screening Program unless revoked earlier.

**I have read and understand this authorization.**

By signing below, I affirm that I am the child's personal representative and have the legal authority to authorize the sharing of their protected health information.

\_\_\_\_\_  
 Print Child's Name

\_\_\_\_\_  
 Child's Date of Birth (MM/DD/YYYY)

\_\_\_\_\_  
 Signature of Parent or Legal Guardian

\_\_\_\_\_  
 Printed Name                      Date

\_\_\_\_\_  
 Relationship to Minor Child

