**PRIVACY PRACTICES AND RELEASE OF MEDICAL INFORMATION**

I hereby authorize StarMed Urgent & Family Care and its affiliates, its employees and agents, to test me, or my minor child. for COVID-19 and use or disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me or my minor child and which identifies my, or my minor child's name, address, social security number, Member ID number) for the purpose of communicating COVID-19 testing information to my, or my minor child's school.

The Company will not use or disclose personal health information beyond the scope of this authorization without my written consent or authorization. I understand that disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

SCHOOL NAME:_____

Student's Name:_____

Student's Signature (18 years of age or older): _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____