Campus School Patient Authorization
to Use and Disclose Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

By signing this Authorization, I hereby direct the use or disclosure by the following named laboratory providing COVID-19 testing, Poplar Healthcare, of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

Name, address and results of testing for exposure to the COVID-19 virus_____

This information may be used or disclosed by the above-named laboratories and may be disclosed to:

Dr. Manoj K. Jain, ordering physician
Shelby County Health Department
City of Memphis assigned designee
Sally Parish (sdgates@memphis.edu)

I understand that I have the right to revoke this Authorization at any time, except to the extent that the above-named laboratories have already acted in reliance on the Authorization. If Authorization is revoked prior to my undergoing the nasal swab test, I understand that I will not be allowed to test. To revoke this Authorization, I understand that I must do so by written request to the above-named laboratory:

Poplar Healthcare: 3495 Hacks Cross Road,
Memphis, TN 38125
ATTN: Joe Davis, Compliance Officer

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for the above-named laboratories to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Poplar Healthcare for following purpose(s):

Management and control of the COVID-19 pandemic within the City of Memphis and Shelby County, Tennessee. _____

The use or disclosure of the requested information will result in direct or indirect remuneration to the above-named laboratories from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: Completion of the COVID-19 testing program within the City of Memphis and the conclusion of the testing program as established by the University of Memphis- Campus School (see school and/or accompanying consent form for testing schedule), which may be modified as reasonably necessary.

Signature: _____ ***Date:*** _____

Personal Representative Information (if signer is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.): _____

If not Parent or Guardian, provide description of the authority of personal representative:

_____

Street Address (if different from above):

_____

City: _____State: _____ Zip Code: _____