

**Authorization for Disclosure of COVID-19 Test Results**

I, \_\_\_\_\_(Employee First and Last Name), hereby voluntarily authorize the disclosure of my COVID-19 test results, provided by the State of Florida, Division of Emergency Management, through Curative, Inc., Curative Labs, and Curative subsidiaries, (Curative Inc.), to me electronically at \_\_\_\_\_(Email), and to \_\_\_\_\_

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(Name and Address of Long Term Care Facility). *\*If employee does not have email, facility may provide results to employee.*

This disclosure is at my request.

I understand that I may revoke this authorization at any time in writing by email to Curative, Inc., at [support@curativeinc.com](mailto:support@curativeinc.com) (with Revoke HIPAA Authorization in the subject line) except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of effectiveness. I understand that I have a right to request and receive a copy of this authorization. I acknowledge that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and any redisclosure may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is effective immediately upon execution.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Printed Name

\_\_\_\_\_  
Date