



COVID-19 Testing Authorization and Consent to Disclosure

I, the undersigned, authorize Northwest Pathology, P.S. ("NWP")/Northwest Laboratory ("NWL"), to administer a test for COVID-19 / SARS-CoV-2, and to use and disclose the results of my test (but no other medical records) to my employer, identified below. This authorization for release of protected health information is effective as of the date below and indefinitely thereafter unless revoked. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand that the results of this test will be released to my employer and results and samples may be stored by NWP/NWL and shared with government agencies and/or medical facilities for purposes consistent with the purposes set forth herein.

Printed Name: _____ Date: _____

Signature: _____ D/O/B: _____

My Employer: Northwest Pathology, P.S. DBA Northwest Laboratory

Employer's Phone No.: 360-734-2800