CURATIVE LABS COVID-19 TESTING AUTHORIZATION

You are entitled to keep your child's protected health information private. This Authorization Form allows you to grant third-party access to your child's protected health information that otherwise would not be permitted.

By indicating your consent below, you authorize Curative Inc., and Curative Labs, LLC, as applicable, to disclose your child's protected health information described below to the persons or entities identified in this form.

I hereby authorize the release of the following protected health information:

- My child's name; and
- The result of my child's COVID-19 (novel coronavirus) test

This information may be released to:

- The Bainbridge Island School District
- Me, as the child's legal personal representative, via SMS though I acknowledge that texts are not secure
- Me, as the child's legal personal representative, via email though I acknowledge that emails are not secure

This information will be used for:

- Addressing the health and safety of our students through medical monitoring of COVID-19 cases at our schools.

I also understand and agree to the following:

- I may refuse to provide this authorization.
- Any information used or disclosed through this authorization may no longer be protected by privacy laws and may be subject to re-disclosure by the person or organization receiving it.
- I have the right to revoke this authorization at any time by doing so in writing to support@curativeinc.com.
- Any revocation of this authorization by me will not apply to actions that Curative Inc. and Curative Labs, LLC, or Dr. Sajad Zalzala M.D. has already taken regarding the sharing of my protected health information during the period that my authorization was valid.
- This authorization will remain in effect for one (1) year from the date it is signed unless otherwise revoked.

I have read and had an opportunity to ask questions about this authorization.

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

_____ _____

Print Minor's Name (*Last, First, Middle Initial*) **Minor's DOB (MM/DD/YYYY)**

_____ _____ _____

Signature of Parent or Legal Guardian **Printed Name** **Date**

Relationship to Minor Child: _____