HIPAA AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION

If you ("Individual") would like your healthcare provider, (as applicable) Vault Medical Services, P.A., Vault Medical Services of New Jersey, P.C. or Vault Medical Services of California, P.C. (collectively "Provider") to disclose the specified Protected Health Information (PHI) to the following designated entity The Ohio State University ("Designated Entity") and its subsidiaries, affiliates, or contractors, you must print your name below to signify your agreement to this authorization ("Authorization") allowing the release of such PHI.

I understand that by printing my name below, this Authorization will become part of my records with Provider and will be associated with my use of the specific test code which I am using for the purposes of receiving a COVID-19 test kit from Provider and processed by RUCDR Infinite Biologics.

A. Provider

	As applicable: Vault Medical Services, P.A. or Vault Medical Services of New Jersey, P.C. or		(212) 880-5494
Provider:	Vault Medical Services of California, P.C.	Telephone:	
Address:	22 W. 23rd Street, 5th Fl	Fax No.:	(212) 365-5547
	New York, NY 10010		

B. Description of Health Records

I hereby authorize the Provider named herein to disclose only the following health records/PHI:

COVID-19 laboratory test results of the RUCDR Infinite Biologics, TaqPath SARS-CoV-2 assay intended for the qualitative detection of nucleic acid from SARS-CoV-2.

C. Purpose of Disclosure

Below is a description of the reason(s) for disclosing my health records:

I am currently associated with the Designated Entity and wish for Designated Entity to be made aware of my COVID-19 test results. The Provider may communicate directly with the Designated Entity regarding my COVID-19 laboratory test results and may release copies of the above identified health records/PHI in order to assist Designated Entity's operations.

D. Designation of Representative(s)

The health records/PHI described above are to be released to Designated Entity(as identified above).

Please read each of the following statements carefully before signing this document:

1. I understand that this Authorization will be valid for three (3) years from the date of signature, or one (1) year from the date of any COVID-19 laboratory test performed by RUCDR Infinite Biologics, whichever is longer, unless I revoke the Authorization or it expires earlier by law.

2. I understand that I may revoke this Authorization at any time, including once health records/PHI described above are released to Designated Entity, by sending the Provider a written notification to legalnotices@vaulthealth.com with the Subject Line "Revocation of HIPAA Authorization." I further understand that revocation of this Authorization will apply and be effective only for future uses and disclosures of my PHI related to COVID-19 laboratory test results of the RUCDR Infinite Biologics, TaqPath SARS-CoV-2 assay intended for the qualitative detection of nucleic acid from SARS-CoV-2, and any such revocation will not be effective for PHI that the Provider has already used or disclosed in accordance with this Authorization.

3. I understand that the provision of treatment by Provider which is connected to or generates the health record/PHI disclosed under this Authorization is conditioned on my execution of this Authorization. I understand such treatment by Provider is solely for the purpose of creating the above identified health record/PHI for disclosure to the Designated Entity. I further understand that if I do not execute this Authorization I will not be able to receive treatment from Provider to use a Designated Entity provided test code to a COVID-19 test kit for the RUCDR Infinite Biologics, TaqPath SARS-CoV-2 assay intended for the qualitative detection of nucleic acid from SARS-CoV-2.

4. I understand that the PHI released under this Authorization may no longer be protected by state and federal privacy laws and may be re-disclosed by the Designated Entity that receives the information, except as specifically indicated herein.

5. I understand that Provider will release the health records/PHI under this Authorization to Designated Entity at no charge to me, however I understand that if I request additional access to my health records from the Provider, the Provider may charge me a reasonable, cost-based fee for copying my health records. This fee can include the cost of supplies and the labor for making copies. Additionally, I understand the Provider may charge me for the actual cost of postage if I request the health records be mailed. These fees do not apply to the release of the health records/PHI to Designated Entity covered by this Authorization.

6. I understand that this Authorization may be executed through the use of an electronic signature in accordance with the Electronic Signatures in Global and National Commerce Act (E-Sign Act), Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act (UETA), and any applicable state law, and that any electronic signature shall be deemed an original signature for purposes of this Authorization, with such electronic signature having the same legal effect as an original signature.

I HAVE CAREFULLY READ THIS AUTHORIZATION AND FULLY UNDERSTAND AND AGREE WITH ITS CONTENTS. I EXPRESSLY CONSENT TO THE USE OF ELECTRONIC SIGNATURE AND UNDERSTAND THAT BY PRINTING MY NAME HERE, I HAVE AFFIRMATIVELY EXECUTED THIS AUTHORIZATION.

[_____] [___DATE____]

OR (If Applicable):

I [_____] am the parent or legal guardian of the minor child [_____INSERT MINOR'S NAME_____] and am executing this Authorization in accordance with the terms and conditions set forth above on their behalf [___DATE_____]