AUTHORIZATION for the Use and/or Disclosure
of HEALTH INFORMATION
(Not to be used for Psychotherapy Notes)

Name: Student Legal First and Last Name Address: Student Home Address

Telephone: Student Cell Phone University of Maine System Student/Empl. ID # Student ID # DOB: Student Date of Birth

Instructions: Please complete all of the sections of this form. Please note incomplete or inaccurately completed forms will not be honored.

I hereby consent to undergo testing administered by ConvenientMD for the purpose of determining my exposure to the 2019 Novel Coronavirus, aka Covid-19. I hereby authorize ConvenientMD to use my health information obtained as a result of or in connection with Covid-19 testing performed by ConvenientMD and further authorize the disclosure of said health information to the University of Maine System, with a primary address of 5703 Alumni Hall, Orono, ME 04469, and The Jackson Laboratory, with a primary address of 10 Discovery Road, Farmington, CT 06032. I hereby acknowledge and understand that the Covid-19 testing performed by ConvenientMD is for the sole purpose of creating health information to be provided to the third parties of the University of Maine System and The Jackson Laboratory and that this authorization is required to be signed before I receive health care. By reading this authorization form, I acknowledge and agree that, if I refuse to sign this authorization, I will not undergo Covid-19 testing provided by ConvenientMD and I may be subject to isolation and other health and safety measures as directed by the University of Maine System as a result.

I understand that results of Covid-19 testing will be provided to me via phone call at the telephone number provided on this authorization, unless otherwise directed.

* Unless otherwise revoked, this authorization will expire on ___________, 20__, or 30 months from the date of signing whichever comes first.
* I understand that I or my personal representative may revoke this authorization at any time by providing a written revocation to ConvenientMD Bangor, ME 207-992-1300, however, revocation will not apply to any previously released information and may be the basis for the denial of health benefits or other insurance coverage or benefits.
* Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.
* I understand that I have a right to a copy of this authorization.
* I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules anymore.
* If I have questions about use or disclosure of my health information, I may contact ConvenientMD Bangor, ME 207-992-1300.

Signature: Student Signature Date: Date of Signing

Parent/Guardian: Parent/Guardian Signature Date: Date of Signing
(if under 18 years of age)

Personal Representative: ______________________________ Date: _________________

IF NOT SIGNED BY THE INDIVIDUAL, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Relationship to the Individual: ____

Describe Authority to Act for Individual: ____

RE-DISCLOSURE OF MEDICAL RECORD INFORMATION IS STRICTLY FORBIDDEN BY RECIPIENTS UNLESS DULY AUTHORIZED BY THE PATIENT.