

EMPLOYEE AUTHORIZATION FOR FLINTRIDGE PREPARATORY SCHOOL'S USE AND DISCLOSURE OF CONFIDENTIAL MEDICAL INFORMATION

CONFIDENTIALITY OF MEDICAL INFORMATION ACT ("CMIA"), CIVIL CODE §§ 56.20, 56.21.

Pursuant to California's Confidentiality of Medical Information Act, I, _____ [Name of Employee], authorize **Flintridge Preparatory School** (or "the **School**") and its employees, representatives, contractors, and agents ("Authorized Representatives") to receive information regarding my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status directly from me and to use and disclose such information, as set forth in this authorization.

This Authorization is Limited to the Following Types of Information:

Information regarding my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status.

Flintridge Preparatory School is Authorized to Use this Information for the Following Purposes:

Where information regarding my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status is necessary for the **School** to (1) to maintain a safe and healthy workplace as required under Labor Code section 6400, et seq.; (2) to permit compliance with federal, state, and local laws, regulations, mandates, orders, or guidance related to COVID-19, including those that take a person's COVID-19 temperature and symptom screening information, COVID-19 test results, and COVID-19 vaccination status into account, such as the Emergency Temporary Standards (Cal/OSHA COVID-19 Regulations) (See 8 C.C.R. §§ 3205-3205.4); and (3) to promote safe and healthy **School** operations for employees, students, families, and other members of the **School** community; and (4) to act in accordance with the federal, state, or local mandates, orders, or guidance.

The Following Parties are Authorized to Disclose this Information for the Above Purposes:

Flintridge Preparatory School and its Authorized Representatives.

The Authorized Parties are Authorized to Disclose and the Following Parties are Authorized to Obtain This Information for the Above Purposes:

School employees who have a legitimate need to know information regarding my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status; appropriate persons where there is a health or safety emergency and the information is necessary to protect the health or safety of the employee or others; appropriate persons as required by federal, state, or local laws, regulations, mandates, orders, or guidance, and any agent, representative, or employee of the **School**, student, parent, visitor, invitee or other member of the public accessing the **School** premises or facilities, etc., who may become aware of my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status as may be impliedly or constructively disclosed by my action(s) or inaction(s) and/or those of the **School** or its Authorized Representatives.

Authorization Period:

The School and its Authorized Representatives are authorized to use and disclose information regarding my COVID-19 temperature and symptom screening information, my COVID-19 test results, and my COVID-19 vaccination status in the manner specified above through **August 15, 2023**.

Right to Receive a Copy of This Authorization:

I understand that if I sign this authorization, I have the right to receive a copy of this authorization. Upon request, **Flintridge Preparatory School** will provide me with a copy of this authorization.

I authorize the uses and disclosures of my medical information as described above for the purposes listed above. I understand that this authorization is voluntary and that I am signing this authorization voluntarily.

Employee's Name

Signature

Date