Authorization for Use or Disclosure of Protected Health Information related to COVID-19 Vaccination Status

Authorization

I hereby authorize _____ (healthcare provider) to use and disclose any and all COVID-19 vaccination records to my employer, the City of Portland.

The purpose for this disclosure is so that my employer can verify my vaccination status. This Authorization covers all past, present, and future periods.

This authorization shall be in full force and effective for a period of one year after my signature date, at which time the authorization is withdrawn.

Acknowledgements

I understand I have the right to revoke this Authorization at any time, and such a revocation shall be made in writing. However, I understand that my revocation will not be effective to the extent that any person or entity has already acted in reliance on this Authorization.

I understand that the covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the I sign this Authorization.

I understand that that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Employee Signature: _____

Date: _____

Printed Full Legal Name: _____

Date of Birth: _____