Shelby County Schools

Patient Authorization to Use and Disclose Protected Health Information

Patient First and Last Name: _____

School where the student is currently enrolled: _____

If the person testing is under the age of 18, print name of parent/guardian below:

Name: _____ Relationship (parent, guardian, etc): _____

By signing this Authorization, I hereby direct the use or disclosure by the following named laboratory providing COVID-19 testing: Poplar Healthcare, of certain protected health information (PHI) pertaining to the patient listed above. This Authorization concerns the following information about the patient:

Name, address and results of testing for exposure to the COVID-19 virus

This information may be used or disclosed by the above-named laboratory and may be disclosed to:

Dr. Patrick Dean, ordering provider
Shelby County Health Department

I understand that I have the right to revoke this Authorization at any time, except to the extent that the above-named laboratory has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request to the below-named laboratory:

Poplar Healthcare:
3495 Hacks Cross Road,
Memphis, TN 38125
ATTN: Joe Davis, Compliance Officer

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that my written authorization is not required for the above-named laboratory to use my protected health information for treatment, payment and healthcare operations.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by Poplar Healthcare for the following purpose(s):

Management and control of the COVID-19 pandemic within the City of Memphis and Shelby County, Tennessee.

The use or disclosure of the requested information will result in direct or indirect remuneration to the above-named laboratories from a third party.

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms.

This authorization expires on: Completion of the 2021-22 academic school year.

Signature: _____ Date: _____

University Schools

Shelby County Schools
Consent to Test for COVID-19

I, the undersigned, give permission for contractors hired by the Shelby County Schools Board of Education (SCBE) to perform PCR nasal swab tests on me/my child to check for infection with the COVID-19 virus. I understand that the nasal swab tests will be performed by contractors trained to perform the tests properly in accordance with standard medical and laboratory procedures, and that the tests will be transported to a laboratory qualified to process the tests and provide results in a timely manner. I further understand that I/my child may be required to avoid attending work/school for at least a ten to fourteen (10-14) day period in the event of a positive test result; and that in the event I/my child have been in contact with another coworker/student who has tested positive for the COVID-19 virus, I/my child may be isolated or sequestered, along with any other coworker/student likewise exposed, separately from other coworkers/ students at work/school, for up to a ten- to fourteen- (10-14)- day period, or as otherwise required by the Shelby County Health Department, even if I/my child have not tested positive for the COVID-19 virus.

I agree and acknowledge that the Shelby County Schools Board of Education (SCBE), its employees, associates, volunteers, personnel and/or contractors will have no liability whatsoever for any claims, damages, demands, judgments and loss including but not limited to illness, injury, and/or death, arising from or otherwise connected with the SCBE and/or its contractors' testing of me/my child for infection with the COVID-19 virus and/or subsequent actions taken by work/school in response to my/my child's test results or the test results of any coworker/student with whom I/my child have been in contact.

I agree and acknowledge that this consent to test shall remain in full force and effect for the duration of the testing program as established by the SCBE and my school/organization.

Patient Legal Name: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date signed: _____