Machaon Diagnostics

## AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL INFORMATION

I authorize Machaon Diagnostics, Inc. to test my sample and subsequent samples for the SARS-CoV-2 virus, the causative agent of COVID-19.

I authorize Machaon Diagnostics, Inc. to report test results to my employer listed below. I understand that I will be notified by my employer (not by Machaon Diagnostics, Inc. directly) if a positive or negative result is measured. The results will be used for managing COVID-19 infections at my company or institution.

I acknowledge that Machaon Diagnostics, Inc. will collect and report my information, as may be required by law to county, state or other governmental entities.

Machaon Diagnostics, Inc. will adhere to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA") defining the use or disclosure of Protected Health Information (as defined at 45 C.F.R. §160.103) ("PHI").

I understand that, as with any medical test, there is the potential for false positive or false negative test results.

I, the undersigned, have been informed about the test purpose, collection procedure, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I authorize the disclosure and use of my medical information as described above for the purposes listed above. I voluntarily agree to ongoing COVID-19 testing as described above.

Name (Print): _____

Signature: _____ Date: _____

Employer: _____