HARVARD UNIVERSITY
Health Services

If your child/dependent is under the age of 18 and is a student, or attending a program, at Harvard University, the following form must be completed, signed and returned prior to your child's/dependent's arrival on campus.

Authorization to Disclose and Use Protected Health Information

Harvard University has arranged for SARS-CoV-2 testing and certain related support and resources (the COVID-19 Resources) to be made available to you as part of Harvard's program to maintain a safe campus and workplace, including for students, employees, employees of vendors and contractors, and certain other individuals who either live on campus or are required to be on campus for significant periods of time. In connection with the COVID-19 Resources, Harvard University Health Services (HUHS) will use and disclose certain identifiable health information (Protected Health Information or PHI) about you as described in the Consent to SARS-CoV-2 Testing and Access to Information, including your SARS-CoV-2 test results. The entities and people inside and outside Harvard with whom HUHS will share your PHI, and that will use your PHI, are those people and entities who: (1) provide the testing, (2) make the results available to you, (3) operate, administer and oversee the testing program and related activities, (4) perform disease control functions, like notifying people who may have been in close, sustained contact with a person who tested positive on the SARS-CoV-2 test or was presumptively diagnosed with COVID-19 infection, and (5) make decisions about whether and when you can participate in person in Harvard-related activities. Your PHI may also be used and shared for other purposes that do not require your authorization, such as if required by law or legal process.

Purpose of this Authorization

By signing this authorization form, you authorize HUHS to share your PHI with entities and people who are performing the functions described above and you authorize HUHS and those entities and people to use and disclose your PHI for these functions.

Expiration of Authorization

This authorization will expire after five (5) years from the date of your authorization.

Your Rights

You understand and acknowledge the following:

◦You are not required to agree to give this authorization, but if you do not, or if you revoke this authorization, you will be ineligible to receive the COVID-19 Resources, which will be required for you to participate in person in Harvard-related activities, like going to work on site at Harvard or living in Harvard facilities. (Note that if you regularly receive your health care at

HUHS, you may continue to access HUHS care on the same terms and conditions as other people who get care there, even if you do not agree to this authorization.)

◦You may revoke this authorization at any time, but to do so, you must request your revocation via electronic mail to privacy@huhs.harvard.edu. Your revocation will take effect upon its receipt, and HUHS will stop at that time using and disclosing any new PHI about you for the COVID-19 Resources. The revocation will not apply, however, to your PHI that has already been used and disclosed, and HUHS and other entities and people described above may need to continue to use and disclose your already-collected PHI to perform vital, necessary functions, like disease surveillance and disease control activities.

◦You can receive a copy of this authorization by contacting privacy@huhs.harvard.edu. You can access the HUHS Notice of Privacy Practices, but that Notice is primarily for the purpose of regular HUHS patients, not people who are only receiving COVID-19 Resources.

◦You understand that this authorization shall apply for each instance that you receive the COVID-19 Resources, including, but not limited to, HUHS' sharing your PHI with the entities or people operating the testing program, performing disease control, and making decisions about participation in Harvard activities.

◦You understand that PHI disclosed pursuant to this authorization may no longer be protected by federal or state privacy laws if the recipient of the PHI is not subject to such laws and that your PHI may be re-disclosed by such recipients without your specific permission.

I, _____, am the parent/guardian of
(please print)

_____, date of birth _____
(please print)

who is currently a minor (under the age of 18).

By my signature below, I acknowledge that I have read and agree to the terms and conditions of this **Authorization to Disclose and Use Protected Health Information**, by which I authorize Harvard University Health Services and other entities and persons to use and disclose my child's/dependent's health information as described above.

_____ Date: _____
(Parent/Guardian signature)