

**Important Note: Company must check applicable state laws concerning the confidentiality of medical information and state privacy laws to make sure employee may waive confidentiality.**

**AUTHORIZATION  
To Disclose COVID-19 Diagnosis**

I understand that the Americans with Disabilities Act, the Family and Medical Leave Act, and other privacy laws prohibit my employer from disclosing my medical/health information. In the interest of the health of my co-workers and others with whom I may have had contact on my worksite, however, I authorize [employer] to disclose to employees at my worksite and to others, i.e., clients, visitors, customers, whom I may have encountered at my worksite, that I have tested positive for the COVID-19 virus or that I have been exposed to the virus. [employer] advised me that I am not required to do so and that there would be no adverse consequences to my employment if I chose not to do so. Further, [employer] did not seek to coerce or pressure me to permit the disclosure.

\_\_\_\_\_  
**Signature of individual**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of the individual**

**SIGNING THIS AUTHORIZATION FORM IS VOLUNTARY**

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