AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL INFORMATION

Confidentiality of Medical Information Act (CMIA), Civil Code § 56, et seq.

Pursuant to California's Confidentiality of Medical Information Act, I, _____,[employee name] am self-disclosing the Medical Information described in this authorization to representatives from the Human Resources Division of the City of Oakley. I also authorize the same representatives from the City of Oakley to use the Medical Information for the purposes described in this authorization.

This authorization is limited to the following types of information:

- ❑ COVID-19 test results, including but not limited to any results of tests administered to detect the presence of the COVID-19 virus (SARS-CoV-2)
- ❑ COVID-19 vaccination cards/proof

The recipients of this information may use the information for legitimate, non-discriminatory business purposes, including but not limited to the following:

- Managing, controlling, and responding to COVID-19 infections among City of Oakley personnel, medical accommodation request(s), workers' compensation claim administration, paid and unpaid leave administration etc.

In addition to the uses and disclosures expressly provided for under and authorized by the CMIA, _____,[employee name] authorizes the City of Oakley to use information related to _____'s [employee name] vaccination status for other

legitimate and non-discriminatory business purposes for which information about the employee's vaccination status is or may be necessary.

Right to Receive Copy of This Authorization:

I understand that if I sign this authorization, I have the right to receive a copy of this authorization. Upon request, the City of Oakley will provide me with a copy of this authorization.

I authorize the disclosure and use of my Medical Information as described above for the purposes listed above. I understand that this authorization is voluntary and that I am signing this authorization voluntarily.

_____ _____

Signature **Printed Name**

_____

Date