PRE-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 other work-related colleagues, I hereby provide advance authorization to authorize The Haartz Corporation to disclose to employees at my work location and to others, (i.e., clients, visitors, customers, whom I may have encountered at my work location), that I have tested positive for the COVID-19 virus or that I have been directly exposed to the virus.

The Haartz Corporation advised me that there would be no adverse consequences to my employment if I chose not to sign this authorization. Further, The Haartz Corporation did not seek to coerce or pressure me to permit the disclosure. I understand that I may revoke this Authorization in writing at any time and such revocation will be effective when delivered to the Human Resources Department, but will not apply to information that has already been released in response to this Authorization.

The Haartz Corporation provides assurance that the only health information to be shared is the positive COVID-19 test result.

I have read and understand the information in this Authorization form.

_______________________________________ _____________________
Employee Signature **Date**

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Printed name of Employee

SIGNING THIS AUTHORIZATION FORM IS VOLUNTARY