



Last Name: _____

First Name: _____

UID: _____

Authorization to Disclose Personally Identifiable Information

I, a student or employee of the University of Maryland, College Park (UMD) who is age 18 years or older, consent to the release of personally identifiable information from my employment records.

I understand that the records to be disclosed include: the last four digits of your **social security number, race, ethnicity, date of birth and gender**. I acknowledge that the purpose of the disclosure is to facilitate my interest in being tested for COVID-19.

I understand that the personally identifiable information will be disclosed by UMD to the University of Maryland, Baltimore (UMB), University of Maryland Medical System (UMMS), University of Maryland, Pathology Associates, P.A. (UMPA), and federal, state and local authorities, as required by law.

By signing below,

I agree to the release of this information.

I do not agree to the release of this information. I understand that I will not be allowed to be tested today.

Student/Employee Signature

Date

Student/Employee 's Printed Name