AUTHORIZATION FOR WEST VALLEY - MISSION COMMUNITY COLLEGE DISTRICT'S USE AND DISCLOSURE OF CONFIDENTIAL MEDICAL INFORMATION

Confidentiality of Medical Information Act ("CMIA"), Civil Code §§ 56.20, 56.21.

Pursuant to California's Confidentiality of Medical Information Act, I, _____ **[Name]**, authorize the West Valley - Mission Community College District ("District") to use and disclose information regarding my COVID-19 vaccination status for legitimate, non-discriminatory business purposes where my vaccination status is necessary for the District to make business or work-related decisions authorized by or in order to comply with federal, state, or local law or regulation that takes a person's vaccination status into account.

Specifically, I authorize the District to use and disclose this information for the purposes provided under the Cal/OSHA COVID-19 Regulations (8 C.C.R. §§ 3205-3205.4), including, but not limited to, decisions regarding the use of face coverings.

This authorization is limited to the following types of information:
Information regarding my COVID-19 vaccination status.

I authorize the District to use this information for the following purposes:
For legitimate, non-discriminatory business purposes where information regarding my vaccination status is necessary for the District to make business and operational-related decisions authorized by or in order to comply with federal, state, or local laws that take a person's vaccination status into account.

I authorize the following parties to disclose this information for the above purposes:
The District and the District's designated agent(s) where:

1. The disclosure of my vaccination status is or may be impliedly or constructively disclosed by my action(s) (*e.g.*, not wearing a face covering during District activities or business); and/or

2. The disclosure of my vaccination status is or may be impliedly or constructively disclosed by action(s) of the District or the District's designated agent(s) (*e.g.*, allowing me to not wear a face covering during District activities or business).

I authorize the following parties to receive disclosure of this information for the above purposes:

Any agent or employee of District, visitor, invitee or other member of the public accessing District's premises or facilities, etc., who may become aware of my vaccination status, by my action(s) and/or those of District (*e.g.*, become aware that I am fully vaccinated by my choice to remove a face covering during District activities or business with District's consent).

Authorization period:
I authorize the parties specified to disclose information regarding my COVID-19 vaccination status in the manner specified above through **June 30, 2022.**

Right to receive a 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 District will provide me with a copy of this authorization.

I authorize the limited uses and disclosures 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.

_____
Name (PLEASE PRINT):

_____ _____
Signature (sign in blue or black ink) Date

Check one – I am a/an:
Student ☐ Employee ☐ Volunteer ☐

Note: This authorization must be in a typeface no smaller than 14-point type – do not alter the current typeface.

Note: This form must be completed by the individual submitting it and must include their own signature in ink or via a certified electronic signature (i.e. DocuSign).