Instructions

Print off a copy of this form. Complete and sign *Part 1 Authorization for Release of Medical Information for Request for Medical Exemption from COVID-19 Vaccination.*

Please give *Part 2: Request for Medical Exemption from COVID-19 Vaccination* to your physician to complete and sign. After your physician has completed and signed the form and returned it to you, please complete, sign and date the attestation at the bottom.

Once Part 1 and Part 2 have been completed, please email the forms to careadvisors@priviahealth.com, or fax the forms to Privia at 866-343-0947. Privia will review the completed forms and begin the interactive process with you.

Part 1: Authorization for Release of Medical Information for Request for Medical Exemption from COVID-19 Vaccination

I authorize the use or disclosure of my individually identifiable health information, as described below, for purposes of reviewing my request for medical exemption from COVID-19 vaccination. I understand that the information I authorize to be used or disclosed possibly may be re-disclosed in accordance with the terms of this Authorization by the recipient and may no longer be protected by federal privacy regulations.

1. **What Information is covered by this Authorization?** This authorization applies to all medical, psychological and/or psychiatric information, records, and reports, including information regarding pre-existing conditions that (a) are in existence while this Authorization is valid (see item 3) and (b) are related to my request for medical exemption from COVID-19 vaccination.

Information to be disclosed may include, but is not limited to, medical history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health providers.

2. **Who is covered by this Authorization?** Any persons or facility that attends, treats, or examines me, including, but not limited to, _____ (insert name of health care provider) is to make this information available to MissionSquare Retirement or its representatives for the purpose of reviewing my request for exemption from COVID-19 vaccination.

When relevant to my request(s), MissionSquare Retirement or its representatives may re-disclose (without further authorization) this information to any of the following: (a) any persons or facility that attends, treats, or examines me; (b) any person or facility that impacts determination of my request for reasonable accommodation or that coordinates my benefits, to the extent permitted by state or federal law; (c) claims administrators coordinating MissionSquare Retirement's short- and long-term disability plans in their capacity as claims administrators; (d) MissionSquare Retirement's worker compensation carrier or its agents or assigns for the purpose of administering workers' compensation benefits; and (e) the Social Security Administration or a Social Security or vocational rehabilitation vendor.

3. **How long is this Authorization valid?** This authorization is valid for the duration of any request or processing of such request for medical exemption from COVID-19 vaccination, unless a different period is required under state law.

4. **Revocation of this authorization**. Unless otherwise provided by state law, I understand that I may revoke this authorization at any time by notifying, in writing, your HR Business Partner. I understand that any revocation will not have any effect on any action taken before the revocation is received.

5. **Refusal to sign**. This authorization may be necessary for the processing of my request for medical exemption from COVID-19 vaccination. Failure to sign this Authorization may impair or impede the processing of my request. I understand my treatment provider will not condition treatment, payment, enrollment, or eligibility on the refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this Authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

Name of Patient: _____

Signature of Patient: _____

Date:_____

Patient's Date of Birth: _____

Printed Name of Representative, if not patient: _____

Relationship to Patient: _____

(Attach Power of Attorney or other legal representation forms)

Part 2: Request for Medical Exemption from COVID-19 Vaccination

Please print the following information:

Name: _____ Phone Number: _____

Date of Birth: _____ Employer: _____

E-mail: _____

Instructions: Please give this form to your physician to complete and sign. After your physician has completed and signed the form and returned it to you, please complete, sign and date the attestation at the bottom. Please email this completed form to careadvisors@priviahealth.com, or fax the form to Privia at 866-343-0947. Privia will review the completed forms and begin the interactive process with you.

FOR THE LICENSED PHYSICIAN

Dear Physician:

A mandatory COVID-19 vaccination policy is in effect across MissionSquare Retirement. The above named person is requesting an exemption from this vaccination requirement. The CDC advises medical exemption from COVID-19 vaccination for certain recognized contraindications https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html.

The Americans with Disabilities Act and applicable state laws also require that MissionSquare Retirement provide reasonable accommodations, including exemption and waiver, to workplace rules/standards when: (1) an individual with a disability is unable to comply with those rules/standards due to a medical condition; and (2) providing such accommodation does not impose an undue hardship on MissionSquare Retirement's operations or finances. This can include individuals who are unable to receive the COVID-19 vaccine due to an underlying physical or mental impairment.

MissionSquare Retirement has provided the above named person with an authorization for the release of medical information relating to this inquiry. A signed copy should be attached. If it is not attached, you will need to ensure that the above named person provides you with an appropriate authorization before sending us your responses.

Please complete the form below consistent with the above information.

Thank you.

The above person should not be immunized for COVID-19 for the following reasons (Please check all that apply):

☐ severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine.

☐ immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the vaccine.

(Vaccine Ingredients: https://www.cdc.gov/vaccines/covid- I9 /info-by-product/clinical-considerations.html#Appendix- C)

Which ingredient caused an allergic reaction?

_____

What was the reaction?

_____

Which brand of the COVID-19 vaccine is contraindicated?

_____

How long will the medical contraindication last? (Please specify date)

_____

Has the patient seen an Allergist-Immunologist? _____

☐ The physical condition of the person or medical circumstances, such as an underlying physical or mental impairment, relating to the person are such that immunization is not currently considered safe. **Please attach a separate statement that describes the medical reason justifying an exception in detail, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine.**

I certify that _____ has the above contraindication(s) and/or need for medical exemption due to underlying medical circumstances and request a medical exemption from the COVID-19 vaccination.

Physicians Signature: _____

Physician Name (printed):_____

Date: _____ License No: _____ State _____

You may return this form to the patient.

FOR THE REQUESTOR (Employee)

I attest that the above information is complete and accurate to the best of my knowledge, and I understand that any intentional misreporting contained in this request could result in progressive disciplinary action, up to and including termination. I also understand that MissionSquare Retirement will evaluate my request in accordance with its legal obligations and the request may not be granted if it creates an undue hardship for MissionSquare Retirement.

Signature: _____ Date:_____

Name (please print): _____