AUTHORIZATION AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Kforce to release to (the "Client") if requested.

- My COVID-19 vaccination status, including the dates I received the dose(s) and my COVID-19 vaccine card
- The results of my weekly/biweekly COVID-19 test results

This information is to be used for the purpose of confirming my authorization to work at the Client's site, consistent with the terms of Kforce's engagement with the Client.

This authorization is in effect until one year from the date shown in my electronic signature below, unless I withdraw my permission sooner as outlined below.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purposes listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily.

I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is required or permitted by law.

420|Andrew B. Sharp|andy@

Name (electronic signature)