**THIS IS A SAMPLE FORM: REVIEW AND REVISE AS NEEDED.**

**You may replace this text with your letterhead.**

**Change font size for larger print as necessary.**

**Version 12/4/20**

**COVID-19 Testing: Informed Consent**

I give my permission for collection and testing for COVID-19 through a nasopharyngeal swab or blood draw, as ordered by an authorized medical provider, public health official, or my employer.

I understand the nasopharyngeal collection procedure and possible risks:

* A thin cotton-tip applicator is passed deep into the nasal passages
* The test may be uncomfortable and may trigger coughing and sneezing
* Some bleeding after the collection may occur, but is not expected
* Failure to obtain a deep swab may result in inaccurate test results

I understand the antibody test collection procedure and possible risks:

* A finger stick or blood draw
* You may have slight discomfort where the needle punctures the skin
* I **understand that a *positive* antibody test result does not excuse me from complying with state mandates and the safety precautions required by my employer**

I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I understand it is my responsibility to determine how COVID-19 services are covered by my insurer.

I understand that the above named practice is not acting as my primary medical provider.

I understand that this testing does not replace treatment by my primary medical care provider. I agree to contact my primary medical care provider to discuss my test results and obtain medical care and treatment, or to ask additional questions about this test.

I have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign and I voluntarily agree to this testing for COVID-19.

PRIVACY NOTICE: I understand that test results will be kept confidential except for disclosures required or permitted under law. HIPAA specifically authorizes disclosure without my consent for certain purposes, including disclosures to a public health authority, government agencies and persons at risk, as well as disclosures to prevent or lessen a serious and imminent threat to the health and safety of a person or to the public. I authorize and consent to these disclosures.

Signature of patient or legal representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_