**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 or public health official.

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 this practice**

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, 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. In this regard, 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 lesson 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_