VOLUNTARY TESTING FOR CORONAVIRUS (COVID-19)

PATIENT INFORMATION

First:	MI:	Last:
Date of Birth:	Gender:	Phone:
Street Address:		PO Box:
City:	State:	Zip:
Email:		

SIGNS AND SYMPTOMS

Do you now have, or have you recently had any of the following:	
Fever Yes or No	Runny Nose Yes or No
Chills Yes or No	Sore Throat Yes or No
Body Aches Yes or No	Cough Yes or No
Congestion Yes or No	Other:

Have you recently traveled to a "Hot Spot" or been in contact with a person known to have COVID-19?

Yes or No	If yes, Date:

INFORMED CONSENT FOR CORONAVIRUS TESTING (COVID-19)

Please carefully read the following informed consent:

1. I authorize Healthy Connections, Inc. (HCI) to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. I understand that I am not creating a patient relationship with HCI by participating in testing. I understand that HCI is not acting as my medical provider. Testing does not replace treatment by my medical provider. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.
6. I acknowledge that I have been given or offered a copy of HCI's Notice of Privacy Policy.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have been offered or received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

____________________________________ ____________________________

Signature of Patient or Guardian Date: