

INFORMED CONSENT FOR COVID-19 TESTING

Name of Individual/Patient _____

Date of Birth _____

Consent for Testing

I verify that I am at least 18 years of age.

I consent to the collection and testing of an oral or nasal swab for the following purpose:

- To see if the sample contains any signs of the coronavirus.

If the individual/patient being tested is a minor. I verify that:

- I am the minor's parent or legal guardian.

As the minor's parent or legal guardian, I consent to the collection and testing of the minor's specimen for the following purpose:

- To see if the sample contains any signs of the coronavirus.

The People Testing You.

The people testing you are not your doctor or medical provider.

I agree that I will:

- Look for medical advice, care and treatment from my healthcare provider if I have questions or concerns
- Look for treatment if I develop symptoms, or if my symptoms change or get worse.

Where Your Tests Will Be Handled.

The Montgomery County Maryland Department of Health and Human Services has designated places to temporarily collect and store test specimens. The County utilizes contracted laboratory services to test the specimens that are collected. All laboratories used for this function are recognized as licensed to perform diagnostic testing for COVID-19 as designated by federal and state regulatory agencies.

I agree to:

- Follow all instructions provided by the specimen collection sites and specimen collection staff.
- Give permission for the designated lab to perform testing on my specimen.

What Kind of Test is This?

Today we will use a test authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA). This test looks for the SARS-CoV2 virus. The SARS-CoV2 virus causes the disease known as COVID-19. This test does not look for any signs that you were infected in the past.

I understand that:

- It is possible that the test may result in a false positive or a false negative.
- Testing is voluntary.
- I may take back my consent at any time before delivery of the test to the lab for testing.
 - I can do this by contacting the Montgomery County Department of Health and Human Services at (240) 777-1755.

Results

Upon completing laboratory analysis of the specimen, the testing lab will make results available to state and local health officials in the jurisdiction you reside as required by law and to the listed referring provider.

I give permission to the Montgomery County Department of Health and Human Services to:

- Contact me using the email address or phone number I provided.
- Send my test results via a secure, encrypted email to the email address I provided.
- Provide me access to my results through a county-maintained or lab-maintained secure web portal.

I understand that:

- I am responsible for checking my email for my results.
- I am responsible for looking at my results when they become available.
- If I receive a positive test result, I may be contacted by a representative of the local or state health department to review the results and explain the next steps I should take.
- I can contact Montgomery County Department of Health and Human Services at (240) 777-1755.

I give permission for my test results to be released to the County, State, or any other governmental entity as may be required by law.

I understand that the results of my test may be released to the Chesapeake Regional Information System for our Patients (CRISP), Maryland's regional health information exchange, which allows my provider to access my test results.

The results of my test will be released to the person or organization that ordered testing.

Cost

Testing services will be provided at no out-of-pocket cost to me.

Privacy & HIPAA Disclosure

The Montgomery County Department of Health and Human Services and its contracted laboratory services comply fully with all laws and regulations regarding privacy, data security, and the Health Insurance Portability & Accountability Act (HIPAA).

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the NPP and agree to its terms.

I may see and copy the information described in this form if I ask for it.

I acknowledge that all my questions were answered to my satisfaction, that I fully understand this authorization form.

This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

Signature of Individual/Patient or Guardian

Date

英文姓 Last Name _____ 性別 男 女
 SEX: Male Female Other
 英文名 First Name _____ 出生日期 _____
 Patient Address _____
 City _____ State MD 郵政編碼 _____
 Ethnicity Hispanic Non-Hispanic Indisclosed HISPANIC 電話 Phone #: _____
 Race Asian American Indian Black/African American Islander White Undisclosed
 EMAIL: _____ Uninsured
 電子郵件地址 _____

Clinician Section

Patient assessment: First test? (YNOU) Employed in healthcare? (YNOU) Patient symptomatic? (Y: onset date _____ NOU)
 Patient has been hospitalized? (YNOU) Hospitalized in ICU? (YNOU) Lives in congregate care? (YNOU) Pregnant? (YNOU)

| DIAGNOSIS CODE | | TEST PANEL |
|--|---|--|
| <input type="checkbox"/> R50.9: Fever unspecified | <input type="checkbox"/> B97.29: Other viral pneumonia | <input checked="" type="checkbox"/> COVID-19 (SARS-CoV-2) Test |
| <input type="checkbox"/> J12.89: Pneumonia COVID 19 | <input type="checkbox"/> Z20.828: Confirmed exposure COVID19 | SPECIMEN COLLECTION |
| <input type="checkbox"/> R05: Cough | <input type="checkbox"/> Z11.5: Special Screen Viral Illness | Collection Date: M M D D Y Y Y Y |
| <input type="checkbox"/> R06.02: Shortness of Breath | <input type="checkbox"/> J22: Unspecified Acute Lower Respiratory Infection | Collection Time: H H : M M AM PM |
| <input type="checkbox"/> Other: | | |
| <input type="checkbox"/> Other: | | <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Oropharyngeal <input checked="" type="checkbox"/> Nasal <input type="checkbox"/> Oral |

Facility Name DENNIS AVENUE HEALTH CENTER
 Facility Address 2000 DENNIS AVENUE
 City SILVER SPRING State MD Zip Code 20902
 Phone #: 240 773 1204 Fax #: 240 777 4750
 Point of Contact MARK ARSENAULT
 Clinician Name DR TRAVIS GAYLES NPI 1184850653

I hereby authorize Patriot Medical Laboratories DBA CIAN Diagnostics to perform the test panel indicated above. I also understand and hereby acknowledge that the tests ordered herein are medically necessary for this particular patient, given the patient's clinical condition.

Verbal Order
 Clinician's Signature _____ Date _____

Client consent to testing and delivery of results collected on separate form.