INFORMED CONSENT FOR COVID-19 DIAGNOSTIC TESTING

1. Authorization and Consent for Covid-19 Diagnostic Testing:

I voluntarily consent and authorize HealthFirst Family Care Center to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by my healthcare provider through a nasopharyngeal swab, anterior nares swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

2. Patient Rights and Privacy Practices

a) Notice of Privacy Practices and Patient Rights: HealthFirst Family Care Centers' Notice of Privacy Practices describes how it may use and disclose your protected health information to carry out treatment, initiate and obtain payment, conduct health care operations and for other purposes that are permitted or required by law. To review a copy of your rights as a patient and HealthFirst Family Care Center's Notice of Privacy Practices please ask our front desk staff. I acknowledge that HealthFirst Family Care Center has provided me with a copy of their Notice of Privacy Practices.

b) Disclosure to Government Authorities: I acknowledge and agree that HealthFirst Family Care Center may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

3. Release

To the fullest extent permitted by law, I hereby release, discharge, and hold harmless, HealthFirst Family Care Center, including, without limitation, any its respective officers, directors, employees, representatives, and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services.

I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

4. Payment

I understand that my insurance company will be billed for these services and should my insurance not cover these costs that I will be responsible for payment of the testing fee up to $100.00.

Patients Printed Name: _____ Date: _____

Patient Signature: _____