



## Patient Consent Form – COVID 19 Testing

**Patient Name** \_\_\_\_\_

**Parent Name** (if under 18) \_\_\_\_\_

**Patient or Parent Signature** (if under 18) \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Authorization and Consent for COVID-19 Diagnostic Testing:**

I voluntarily consent and authorize Diligent Urgent Care, LLC (DUC) 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, 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 questions or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

### **Release of Records:**

I authorize **DILIGENT URGENT CARE, LLC** to release (verbal or written) confidential medical information to any person or entity that is related in any way to this visit or a previous COVID test visit, in accordance with national and state laws that apply.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me. (Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I agree, with respect to my COVID-19 test, to authorize the test results to be provided to Camp Zeke.