Edinger Urgent Care

Informed Consent for COVID-19 Testing

COVID-19 PCR Nasal Swab

You are being given this Consent Form because your sample(s) will be tested for the Coronavirus Disease 2019 (COVID-19) using the Centers for Disease Control and Prevention's (CDC) 2019-nCoV Real-Time RT-PCR Diagnostic Panel. This is a lab-based test that will take between 24-72 hours to obtain results. This test is recommended if you are having symptoms such as coughing, fever, loss of taste and smell or if you are experiencing no symptoms but have been exposed to someone who tested positive. This test is required for those who are travelling.

COVID-19 Antigen Nasal Swab (RAPID TEST)

The BD Veritor™ System for Rapid Detection of SARS-CoV-2 is a chromatographic immunoassay for the direct and qualitative detection of SARS-CoV-2 antigens in nasal swabs from patients with signs and symptoms who are suspected of COVID-19. A positive result is highly accurate, but a negative result does not rule out infection. Results are reported within the hour to you.

Acknowledgments

1. I authorize Edinger Urgent Care personnel to collect samples for COVID-19 testing
2. I authorize my test results to be disclosed to the County or State Health Department when it is required by law
3. I acknowledge that a positive COVID test is an indication that I must self-isolate and/or wear a mask or face covering in order to avoid infecting others.
4. I understand that, as with any medical tests, there is a potential for inaccuracy, to either report a positive result when in reality it was a negative or vice versa.
5. I understand the testing does not replace treatment by a medical provider. I agree I will seek medical attention or treatment if I have additional concerns or if my condition worsens, regardless of the test results
6. I consent to allow Edinger Urgent Care to email my COVID-19 test results to the email address documented below.

For employees sent by their employer only

I hereby and expressly authorize Edinger Urgent Care to disclose my COVID-19 test results to my employer **Initials:** _____

Test to be performed: ◯ **COVID Nasal PCR** ◯ **COVID Rapid Antigen**

I have read, understand, and acknowledge all the above:

Patient Signature/Consent: _____DOB:____/___/_____

Name: _____ Last Name: _____

Address: _____City: _____ State: _____ Zip:_____

Phone: _____ Date Symptoms first started: _____

Symptoms: _____ Occupation: _____

Email: _____