



## **SENECA HEALTHCARE DISTRICT**

### **Informed Consent: COVID-19**

This document is for reference purposes only. It is intended to provide general guidance, is not legal advice and is not a statement regarding any standard of care. This document does not take into account every law or requirement of federal, state or local authorities.

Please carefully read and sign the following Informed Consent:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasal, nasopharyngeal swab or blood draw, as ordered by an authorized medical provider or public health official. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by Federal, State or local laws. I acknowledge that a positive test result is an indication that I must self-isolate and or wear a mask or face covering as directed in an effort to avoid infecting others.

I understand the testing unit is not acting as my medical provider. This testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results.

I agree that I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I understand that I may receive a phone call from Seneca Healthcare District regarding my test results.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I will receive a copy of this Informed Consent upon request. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time.



## SENECA HEALTHCARE DISTRICT

### Informed Consent: COVID-19

I voluntarily agree to this testing for COVID-19.

By signing this form, you acknowledge that you understand the risks and benefits of receiving testing for COVID-19.

Your signature documents permission for you (or the patient) to receive COVID-19 testing.

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Today's Date

Time:

AM/PM

Patient's Date of Birth

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Legal First Name

Preferred First Name

Last Name

Printed Name of Patient \_\_\_\_\_

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Signature of Patient or Legally Authorized Representative

PERSON OBTAINING CONSENT: I have explained the testing for COVID-19 to the patient/authorized legal representative and I have answered all questions to the best of my ability.

**PATIENT LABEL**