COVID-19 TESTING – INFORMED CONSENT & PRIVACY PRACTICES

Please read carefully and sign the following Informed Consent & Notice of Privacy Practices

INFORMED CONSENT:

I authorize siParadigm Diagnostic Informatics to collect and test for COVID-19 (SARS-CoV-2) through a nasopharyngeal, nasal or oral swab, as ordered by an authorized medical provider or public health official. I also understand that this procedure is semi-invasive and I may experience mild pain and discomfort and possible bleeding.

I understand that this test detects if the SARS-CoV-2 (the virus that causes COVID-19) is present at the time of testing only. It does not test for immunity of if the virus has been present in the past.

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

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

I authorize my information and results to be shared with the county, state, or any other governmental entity which is required by law for COVID-19 tests.

PRIVACY PRACTICES:

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

My signature below is consent for siParadigm to perform COVID-19 testing as required, and report as noted above AND my acknowledgement of the practice's privacy policy.

Print Patient Name:____ DOB:__________________

Patient Signature:____ Date:_________________

Parent/Guardian Name:_____________________________________ Relation to patient:________________

Parent/Guardian Signature: ____ Date:__________________

Email: ____ Contact Number ____________________