AUTHORIZATION OF COVID-19 TEST & RELEASE

The Testing Program is intended to give eligible employees and community members information for use in determining whether they should seek additional medical treatment and/or take other actions, such as self-quarantine or self-isolate, in an effort to prevent the potential spread of the virus to others. The Testing Program is not intended to, and does not, provide medical advice, and you are urged to seek medical advice from your physician.

This authorization will allow [clinic name] to work with [employer name] to discuss and coordinate your care for COVID-19 testing and recovery.

This authorization provides [employer] with your permission to perform a COVID-19 screening procedure based on [employer]'s need to maintain a safe environment for employees, contractors, vendors, and other essential persons with whom you may come into contact. By signing below, you are indicating that you voluntarily consent to this procedure for the detection of COVID-19.

The test being administered involves a nasal swab that will be tested to indicate the potential presence of COVID-19. This test has been approved by the FDA, however, this test alone may not be sufficient to detect or rule out the possibility that you have been exposed to or are infected with COVID-19. You should carefully monitor your own symptoms and, notwithstanding the results of any testing, you must stay home and consult with your physician if you experience symptoms of COVID-19.

You have the right to discuss the proposed testing with your physician, to learn about the purpose, potential risks and benefits of any testing. Based upon your test results, if you are denied entry to [company], you should contact a physician or other medical professional for advice. Because of the ongoing public-health crisis, it may be necessary for _________ to share the results of your test with public health authorities.

This consent is effective from the date signed and will expire in one year. This authorization applies to any lab tests results related to COVID-19 screening after the date of your signature.

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 may revoke this consent at any time by sending written notice to the [clinic name]. I understand this consent is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

By signing below, you consent to the disclosure of such information as requested, recommended or required by federal, state, and local public health authorities.

By signing below, you agree to release and waive any claim arising from your selection to receive this voluntary screening that may arise against [Company] and its designated medical providers and staff members.

Printed Name of Employee ____________________________________

Signature ____

Date _______________________________