NSHC Covid 19 Testing Consent Form

Patient's Name (Print) _____ Date of Birth_____

PO Box: _____Phone Number (cell for texted results):_____

City/Village: _____ Current Insurance: _____

Purpose: To provide school-based testing for the SARS-Co-Vi-2 virus which causes the COVID19 disease in a school based testing strategy.

This consent/refusal will be valid from date signed until May 1, 2021 unless replaced in writing.

Risks: Mild discomfort at the time of testing

Benefits: Community surveillance and early detection of the virus which cases COVID19 to reduce the risk of community spread of the virus.

Consent to Test: I give consent for Norton Sound Health Corporation (NSHC) staff to provide testing for the SARS-CoVi2 virus to the above-named patient during school based testing. I understand that results will be recorded in the Norton Sound Health Corporation medical records system. I understand that I have to right to refuse any proposed testing. I understand there is a small risk of false negative results in and COVID19 testing. I consent to be contacted about the results of the testing by text message or telephone as needed.

Consent to Release Medical Information: I give consent for NSHC and its medical providers to release medical information from this visit as necessary for coordination of care, public health, and/or completion of the claims/payments of the bill for services rendered. I request that any payments from my insurance company(ies) or medical program be made directly to Norton Sound Health Corporation.

*NSHC may release COVID19 test results to the school and school district office as necessary to facilitate travel and event coordination

NSHC will not balance bill or charge copay, co-insurance, deductible or any other charge to the patient for COVID19 testing.

I understand that I may revoke this consent in writing at any time, except to the extent action has been taken based on this authorization by NSHC.

☐ **I want (or my child) to receive COVID19 testing.**

☐ **I do not want (or my child) to receive COVID19 testing.**

Parent/Guardian Printed Name (or patient if age > 18): _____

Parent/Guardian Signature (or patient if age > 18): _____

Date:_____