

COVID-19 Testing Consent Form

I acknowledge and understand that I will perform the following specimen collections on myself: (i) a nasal swab for SARS-CoV-2 PCR testing. SARS-CoV-2 is the virus that causes COVID-19. I acknowledge and understand that if I am consenting to nasal swab testing for SARS-CoV-2 PCR for a pediatric individual age 3-12 an adult will perform their nasal swab collection, if they are age 13-17 an adult will supervise their nasal swab self-collection; however, if they are below the age of three I acknowledge and understand that a health care provider will conduct their nasal swab collection. I further acknowledge, understand, agree, certify, and authorize the following:

1. I have requested testing of my, my ward, or my child's specimen for SARS-CoV-2.
2. The SARS-CoV-2 PCR test involves a swab slid into the nostril to obtain a sample. It may be uncomfortable, painful, or potentially cause mild abrasion or bleeding. No long-lasting side effects from testing are expected. There is minimal risk with collection of a specimen with a nasal swab, but the nature of the collection may cause slight discomfort.
3. I understand that CEI, or an affiliated reference laboratory will perform the laboratory analysis on my specimen if I order SARS-CoV-2 PCR testing. I authorize CEI or a reference laboratory to perform SARS-CoV-2 PCR testing on my specimen.
4. Processing of the specimen and results may take between 3 to 4 days.
5. My results will be reported to Clinical Enterprise, Inc. Clinical Enterprise will make my test results available to the Assure™ digital health platform. If my specimen is individually tested, my test results will be available to me through the Assure™ platform.
6. These procedures and the results are not a substitute for medical advice or treatment from my personal health care provider. I will consult with and obtain care from a health care provider if I have tested positive for COVID-19, am experiencing symptoms, or have any other questions or concerns.
7. I am not entering into a doctor-patient relationship with CEI, Affinity Empowering, Inc., or another reference laboratory. Any questions that I have, or coordination of required follow up with a health care professional, is my responsibility.
8. CEI and its affiliates have infectious disease reporting responsibilities under applicable governmental regulations and will report my testing information in accordance with applicable regulations.
9. CEI and its affiliates also have reporting responsibilities under applicable governmental agreements providing for this testing, and will report my testing information in accordance with applicable agreements.

By clicking below, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree that I and my heirs, executors and assigns hereby release CEI, Affinity Empowering, and other reference laboratories, including their respective employees, agents, and contractors from any and all liability and claims. I authorize CEI, its reference laboratories, and their respective employees to use and/or disclosure the PHI as described above. I do hereby expressly

and voluntarily authorize this use and release of information and declare that the information provided on this form is true and correct.

Last Updated 07 September 2021

By signing "I Agree and Consent," I am accepting and agreeing to be bound by this agreement and I represent and warrant that I have the right, authority, and capacity to accept and agree to be bound by this Agreement on behalf of myself or for those of which I am the legal guardian.

For Guardian and Minors:

Name of Minor: FirstName_____LastName_____

Birthdate_____

Name of Parent/Guardian: FirstName_____ LastName_____

Cell phone number and email address for receiving COVID-19 test results

Cell Phone _____ Email_____

Parent/Guardian Signature_____Date_____

For My Ward:

Name of Ward: FirstName_____LastName_____

Birthdate_____

Name of Guardian: FirstName_____ LastName_____

Cell phone number and email address for receiving COVID-19 test results

Cell Phone _____ Email_____

Guardian Signature_____Date_____

For All Other:

Name: FirstName_____LastName_____

Birthdate_____

Cell phone number and email address for receiving COVID-19 test results

Cell Phone _____ Email_____

Signature_____Date_____

