Essentia Health

COVID-19 TESTING CONSENT & AUTHORIZATION

Name of Individual Receiving COVID-19 Test *(or patient label)*:	**Date of Birth:**
Telephone Number – ***We may call or text this number with important information, including your results:***	**E-mail Address:**

COVID-19 is an infectious disease caused by a novel coronavirus. For many, the illness is mild or does not produce symptoms; however, the elderly and those with underlying medical problems are more likely to develop a serious illness that may result in hospitalization or even death. As the virus is highly transmissible prior to any symptoms or signs of infection, widespread testing is used to detect the disease, monitor transmission, and protect the health and safety of the community.

INFORMED CONSENT FOR COVID-19

- I consent to initial and follow up testing by Essentia Health with a nasal or oral specimen to be obtained in accordance with the manufacturer's instruction and guidance from the applicable Department of Health.
- I understand that, as with any medical test, there is the potential for false positive or negative test results. I also understand that I might experience slight discomfort in my nose or throat and may experience bleeding from the nose.
- I understand that my results could be provided to me by phone, email, and/or MyHealth/MyChart. For more information about how your results will be provided to you, please ask a representative at your test site.
- If I am responsible for the cost of my test, I consent to Essentia Health billing my insurance (or the government if I don't have insurance) for initial and follow-up COVID-19 testing. I authorize my insurance or the government to pay Essentia Health directly on my behalf.
- I acknowledge that a copy of the Essentia Health Notice of Privacy Practice has been made available to me and is available on the Essentia Health website and upon my request.
- I understand that Essentia Health will release my initial and follow-up COVID-19 test results to local and state public health departments and to any other governmental entity as may be required by law.
- I authorize Essentia Health to release my information for treatment, payment, and healthcare operations purposes as further described in the Essentia Health Notice of Privacy Practices.
- I authorize Essentia Health to release information from my medical records to external researchers solely for medical or scientific research. This authorization may be revoked at any time or I can opt out by checking here: [ ]
- Results disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by privacy laws.
- My consent to the release of my information lasts for one year. I understand that I may revoke it at any time by notifying Essentia Health in writing, and the revocation will be effective on the date notified except to the extent action has already been taken in reliance on this authorization. I can request a copy of this consent.
- I, the undersigned, have been informed about the test purpose, procedure, benefits, and risks, and I may receive a copy of this consent upon request. I had the opportunity to ask questions before signing, and I understand that I can ask questions at any time. I voluntarily agree to initial and follow-up COVID-19 testing, and understand that I can revoke my consent at any time.

SIGNATURE of Test Recipient (or legal representative & authority to sign)	**Date Signed *(mm/dd/yyyy)***

<u>COMPLETE ONLY IF DIRECTED</u>: AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS

I authorize Essentia Health to release my initial and follow-up COVID-19 results to the following organization so that they may take necessary precautions. If the purpose of this COVID-19 testing is to create information for disclosure to this organization, Essentia Health may refuse to perform the COVID-19 test if I refuse to execute this authorization.

Organization Name: _Camp Foley___ Contact Information: Marie Schmid or Alli Faricy; _fun@campfoley.com; 218-534-6161__

SIGNATURE of Test Recipient (or legal representative & authority to sign)	**Date Signed *(mm/dd/yyyy)***

IF APPLICABLE: Date Verbal Consent Provided: _____ Time Verbal Consent Provided: _____

Signature of Witness Obtaining Test's Verbal Consent: _____

Printed Name and Title of Witness Obtaining Test Recipient's Verbal Consent: _____