

## INFORMED CONSENT FOR COVID-19 DIAGNOSTIC TESTING

I, \_\_\_\_\_, Authorization and Consent for Covid-19 Diagnostic Testing: I voluntarily consent and authorize \_\_\_\_\_ to conduct collection of my COVID-19 sample. I authorize and consent \_\_\_\_\_ to send my sample for testing, and analysis for the purposes of a COVID-19 diagnostic test to American Specialty Lab.

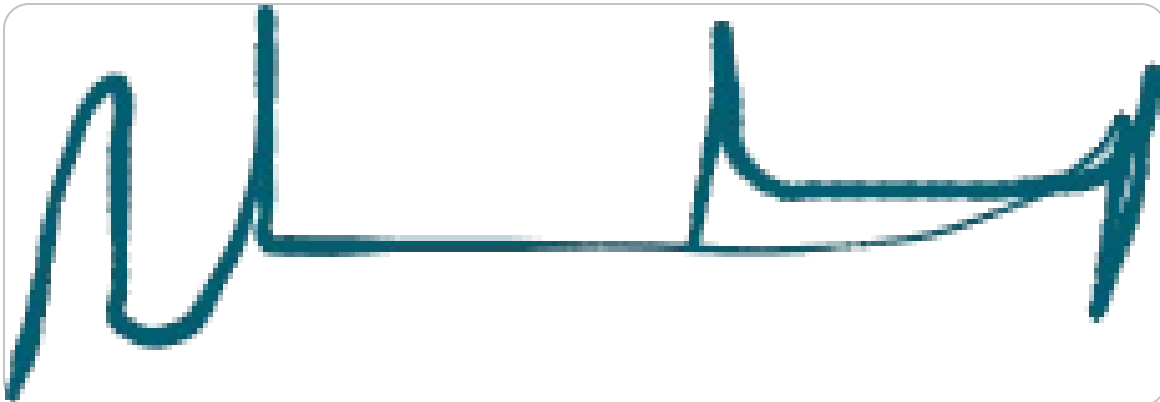
I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by \_\_\_\_\_ through a nasopharyngeal swab, oral swab, or other recommended collection procedures.

I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have questions or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

**Signed Date** : \_\_\_\_\_

**Phone Number**: \_\_\_\_\_

**Patient's Signature** :

A handwritten signature in blue ink, appearing to be 'N. [unclear]', enclosed in a rounded rectangular box.

CLIA #23D2102809