AMERICAN SPECIALTY LAB

# INFORMED CONSENT FOR COVID-19 DIAGNOSTIC TESTING

I undefined, Authorization and Consent for Covid-19 Diagnostic Testing: I voluntarily consent and authorize (undefined) to conduct collection of my COVID-19 sample. I authorize and consent (undefined) 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 or an appropriate sample by (undefined) 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 raise 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** :undefined
**Phone Number**:undefined
**Patient's Signature** :

CLIA #23D2102809