cassia
AN AUGUSTANA/ELIM AFFILIATION

COVID-19 Testing: Long-Term Care Staff and Resident Consent Form

Name of Resident or Staff: _____ **Date:** _____

COVID-19 is an infectious illness caused by a newly discovered coronavirus. For many, the illness is mild or does not produce symptoms; however, the elderly and those with underlying medical problems (such as heart disease, diabetes, chronic respiratory disease, and cancer) are more likely to develop a serious illness that may result in hospitalization or even death. We, the Minnesota Department of Health (MDH), are offering you a COVID-19 test because you work or reside in a long-term care facility where residents may be at risk of serious illness.

Privacy Notice

We are collecting your test sample and other information to determine if you have COVID-19 and to provide you with information on your results. You are not legally required to provide this data, but if you do not provide this information, we cannot test you. The only people who will have access to private information, such as your name and medical information, will be the laboratory conducting the test, your insurance provider, public health staff from the Minnesota Department of Health, local public health, or their contractors to conduct disease investigations or other public health activities, or other persons or entities authorized by law.

Consent

Through your signature or verbal consent indicated below, you certify that you have had the procedure for COVID-19 testing explained to you, and that you have had the opportunity to ask questions about the test. You have also been informed of the risks and benefits associated with the test, including the possibility of slight discomfort in the nose or throat, bleeding from the nose, or an incorrect result. If you undergo testing, you acknowledge that you did so voluntarily. If you decline testing, you understand that you may carry or transmit COVID-19, even if you do not have symptoms. Employees who decline testing will not be allowed to work per current COVID-19 protocol.

You also understand that **your records** are protected under State and Federal privacy laws and cannot be disclosed without your written consent, unless otherwise provided by law. By providing your consent to be tested, you authorize your information and test results to be shared as described in the above Privacy Notice.

_____ **(initial)** I hereby **give my permission/consent** to COVID-19 testing per CDC/State guidance. If verbal consent received staff to indicate below who gave verbal consent:

Verbal consent given by:_____

SIGNATURE – Staff or Resident:	Print:	Date (mm/dd/yyyy):
SIGNATURE – Parent or Guardian:	Print:	Date (mm/dd/yyyy):