Consent to Test Form

Legal First, and Last Name of Child: ____

Recover Health has been contracted to perform testing for COVID-19. As a parent or guardian,

I, ____________________________, hereby authorize Recover Health to perform a viral test to

check specimens from my minor child's: ______________________________, nose to find out if my student is currently infected with the virus that causes COVID-19.

I understand that this information is considered a health record. Further, I understand that by signing this release, I am waiving my right to keep this information confidential from the Centers for Disease Control and Prevention (CDC) under the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that this consent does not establish a patient-provider relationship between Recover Health and myself (or the person being tested if parent/guardian/POA is signing) and that services are being provided for the limited purpose of COVID-19 testing. Should follow-up medical care be required, it is my responsibility to seek it through a primary care physician or health clinic.

I certify that my consent for testing is entirely voluntary and only for the purposes of the test conducted on the date below. I certify that I understand this consent to test can be revoked at any time in writing but will not be effective for materials released under it.

Signature: _______________________D/O/B: ________________ Date: _________________

Name of Minor Child: __________________________________ D/O/B: __________________

Email: _________________________ **Address:** __________________________

Phone#: _______________________ **City/State/Zip:** _____________________

Gender: _______________________ **County:** ____________________________

Race: _________________________ **Ethnicity** __________________________