TERRELL RAPID COVID TEST

Safe drive-thru testing

TERRELL Rapid COVID Test

PATIENT REGISTRATION

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Age: _____ Date of Birth: _____ Sex: ____ Ethnicity (H NH) _____Race: _____

Chronic Medical Problems:	Previous Surgeries:	Medications:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:	Social History:	Drug Allergies:
_____	Tobacco Use:_____	_____
_____	Alcohol Use:_____	_____
_____	Illicit Drug Use: _____	_____
_____	Occupation: _____	_____

Do you currently have symptoms of Covid-19? Yes:___ NO: ___

Symptom: _____

Date Symptoms started: _____

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INFORMED CONSENT

- I authorize this Covid-19 testing unit to conduct collection and testing for Covid-19 through a nasopharyngeal swab as ordered by the medical provider.
- I authorize my test results to be disclosed to the county, state, or any other provider or public health official.
- I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.
- I understand the testing unit is not acting as my medical provider, this test does not replace by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19. I have been informed of HIPAA "Notice of Privacy Practices" and will be furnished a copy on request.

Furthermore, I authorize employees and agents, including physicians, nurse practitioners, physician assistants, medical assistants and other employees and staff members of the above-named company to render medical evaluations and care to the patient indicated on this form. The duration of this consent is indefinite and continues until revoked in writing.

Patient Name (please print) Date

Signature of Patient, Parent, Legal Guardian or Responsible Party

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Witness: