



Accurate Medical Lab

| COVID-19 Testing Consent | |
|--|---------------|
| Authorizing Provider: | Testing Site: |
| <input type="radio"/> Nasopharyngeal <input type="radio"/> Oral <input type="radio"/> Mid-turbinate | Lab Assigned: |
| Type of Test: | |

| Minor's Information | |
|---|--------------------------|
| Minor's Name (Last, First Middle) | Minor's DOB (MM/DD/YYYY) |
| Preferred Parent/Guardian Phone Number | Minor's Address |
| <p>I authorize that a test sample be taken for COVID-19 as ordered by the authorizing provider (or my child's or legal dependent's physician or authorized healthcare provider). I do hereby consent to any physician or health care provider or authorized provider examining or testing my minor child to use or disclose protected health information for reporting purposes.</p> | |
| <u>SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILD UNDER 18</u> | |
| <p>I, _____, have the following relationship with the person above:</p> <p> <input type="radio"/> Father <input type="radio"/> Mother <input type="radio"/> Stepfather <input type="radio"/> Stepmother <input type="radio"/> Court ordered legal guardian <input type="radio"/> Grandfather <input type="radio"/> Grandmother <input type="radio"/> Adult Aunt <input type="radio"/> Adult Uncle <input type="radio"/> Adult Brother <input type="radio"/> Adult Sister </p> <p>I have the legal authority, based on the relationship to the child as indicated above pursuant to s. 743.0645, F.S., to consent to this test administration for the child named above.</p> | |
| Parent or Guardian Signature | Date |