INFORMED CONSENT FOR COVID 19 TESTING

Please carefully read and sign the following Informed Consent:

1. I authorize a Precision Clinical laboratory (PCL) to conduct collection and testing for COVID-19 through a nasopharyngeal swab. **Initial_____**

2. I authorize my test results to be disclosed to the

   A. CDC, State health authorities as may be required by law. **Initial_____**

   B. The appropriate aviation authorities (If for traveling purposes). **Initial_____**

3. 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 by CDC to avoid infecting others. **Initial_____**

4. I understand that PCL is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. **Initial_____**

5. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. **Initial_____**

6. I understand that insurance companies may not cover expenses for travel purposes, hereby I understand this is an out of pocket expense. **Initial_____**

7. This consent form will stand valid in the case of retesting. **Initial_____**

8. The Covid-19 service fee applied is for the expedited service only. **Initial_____**

With my signature, I denote that I understand the informed consent form in its entirety and I voluntarily agree to this testing for COVID-19.

Full Name: _____

Date: _____

Signature:_____