PCL PRECISION CLINICAL LAB & IMAGING

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_____

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

I have received a copy of this Informed Consent. I voluntarily agree to this testing for COVID-19

Are you International Traveler ?

Yes ☐

No ☐

Are you Exposed ?

☐ **Yes**

☐ **No**

Do you have Symptoms?

Yes ☐

No ☐

Have you been tested at PCL before

☐ **Yes**

☐ **No**

Full Name : _____ **DOB:**_____ **Sex:** _____

Address :_____**City** _____**State** _____

Zip code _____ **Phone #** _____ **Email** _____

Insurance Name _____ **ID** _____ **Group#** _____

For Travelers only

- **Passport #** _____

- **Arline** _____ **Flight Date & Time** _____

- **Final destination** _____