COVID-19 TESTING AND DIAGNOSIS AUTHORIZATION AND CONSENT

Name: ____ **Birth Date:** ____________________

AUTHORIZATION AND CONSENT

I authorize Offshore Aviation and its clinical affiliates or an independent laboratory acting on their behalf (collectively "OAG LABS") to **disclose my identifiable health information related to my COVID-19 testing and diagnosis to the Saint Mary's County Health Department (SMCHD) Official**s in accessing and evaluating my Covid-19 results for follow-up purposes, including quarantine, exposure evaluation, and contact tracing purposes.

I have requested that OAG LABS provide testing and diagnosis for Covid-19 to me so that the information may be shared with **authorized personnel**. I understand that my refusal to sign this form means that OAG LABS will not render such testing and diagnosis for Covid-19 on my behalf. Otherwise, OAG LABS may not condition my testing, diagnosis or treatment on signing this authorization. I also understand that once OAG LABS releases my identifiable health information, federal and state privacy laws may not protect the information, and the entity receiving my information may re-disclose it.

This Authorization to Release Information will be valid for four years from the date of my signature. If I change my mind and no longer wish for my identifiable health information related to my COVID-19 testing and diagnosis to be shared with **SMCHD**, I must let OAG LABS know in writing by contacting the OAG LABS Administrative Staff (contact information set forth below). OAG LABS clinical affiliates will then no longer share my identifiable health information related to my COVID-19 testing and diagnosis with **SMCHD officials** (although OAG LABS will not be able to take back any disclosures that it made while this authorization was in effect), and OAG LABS may inform **SMCHD** of such election.

I voluntarily consent and authorize OAG-LABS ("OAG") to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 screening will require the collection of an appropriate sample by my healthcare provider through a nasopharyngeal swab. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and that while there is an extremely high accuracy with PCR testing there is also a .6 percent chance of a false negative test result. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, OAG-LABS, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

By signing below, I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to sign this form.

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Patient or Patient's Legal Representative Signature

Date:____

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