



3298 Summit Blvd. #33
 Pensacola, FL 32503
 Phone: (850) 434-6168

COVID-19 Testing: Informed Consent

Date: _____		Company name: _____	
Name: _____	DOB: _____	€ Male	€ Female
Address/City/State/Zip _____			
Phone: _____			

- I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a blood draw. I voluntarily agree to this testing for COVID-19.
- I am aware that there may be adverse reactions associates with having my blood drawn as fainting, mild pain & bruising. I believe that the benefits outweigh the risks and assume full responsibility for any reaction that may result.
- I authorize ProHealth to release the results of my blood test to the above company
- I understand and accept the risk of this practice sending my Personal Health Information (PHI) through email or fax. I understand such transmission is necessary for the purpose of healthcare treatment.
- I authorize my test results to be disclosed to the county state, or to any other governmental entity as may be required by law. Such reporting will be done with discretion and will follow Federal and State regulations.
- I understand that my test results **do not** constitute a medical opinion or medical advice. My test results are not medical care, treatment, a treatment recommendation, or a diagnosis. I must follow up with my physician to interpret any information that is provided by ProHealth.

 Signature Date

TO BE COMPLETED BY TECHNICIAN

Tests: ___ Negative—No exposure to virus
 ___ Positive IGG—Past exposure/infection but no current active disease
 ___ Positive IGM—Recent exposure/infection and recommend COVID genetic test and isolate for 14 days
 ___ Positive IGG & IGM—Current infection and may have had it for some time. Recommend COVID genetic test and isolate for 14 days

Results cannot completely rule out COVID infection as recent exposure may not have had enough time to develop antibodies.

MFG: _____ Lot #: _____ Exp date: _____

Technician _____

Date: _____