Knox Public Health
Protect • Promote • Prevent

COVID-19 Testing Consent Form

Patient Information					
Last Name		**First Name**			**MI**
Date of Birth/Age		**Ph #**		**SS#**	
Home Address					
City	**State**		**Zip**	**County**	
Gender	**Race**	**Ethnicity** ☐ Hispanic/Latino		☐ Not Hispanic/Latino	
Insurance Information					
Medicare Plan/Number:		**Medicaid Plan/Number:**			
Private Insurance Company Name:					
Member ID#		**Group #**			
Insured Name/DOB:		**Relationship to Insured:**			

Informed Consent for COVID-19 Testing

Please carefully read the following informed consent:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.

b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.

d. I understand that I am not creating a patient relationship with Knox Public Health by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

e. I understand that, as with any medical test, there is the potential for false positive or false negative test results.

f. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

Patient/Guardian Signature:_____ Date: _____

Relationship to Patient: _____