



# ARIZONA DEPARTMENT OF HEALTH SERVICES

## COVID-19 Testing : Informed Consent

Please carefully read and sign the following Informed Consent:

- a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab or blood draw, 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 self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.
- d. I understand the testing unit 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. 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 a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

\_\_\_\_\_  
Date

Staff       Resident

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Signature of staff, resident or resident's appointed guardian