APPENDIX A – RELEASE OF INFORMATION AND INFORMED CONSENT

SOUTH DAKOTA DEPARTMENT OF HEALTH

RELEASE OF INFORMATION AND INFORMED CONSENT TO COVID-19 TESTING

Name:_____ DOB:_____

Address:_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Please carefully read and sign the following Informed Consent:

1. I authorize this COVID-19 testing unit to conduct specimen collection and laboratory testing for COVID-19 through nasal swab, as ordered by an authorized medical provider or public health official.
2. I authorize my test results to be disclosed to the South Dakota Department of Health and School District Contact.
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 to avoid infecting others.
4. I understand the South Dakota Department of Health 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 regard 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.
5. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
6. 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 additional questions at any time. I voluntarily agree to this testing for COVID-19.

Signature:_____ Date:_____

Person to be tested *(If minor, parent or guardian signature)*

This form must be signed prior to specimen collection