

**Authorization For COVID-19 Testing**

Quadrant Laboratories LLC, a subsidiary of Quadrant Biosciences Inc, has been engaged to perform COVID-19 testing of saliva specimens for an organization you are affiliated, Andover CSD. The testing may be for screening and/or diagnostic purposes related to the SARS-CoV-2 virus. For screening purposes, your saliva specimen may be combined with saliva specimens from other individuals into a single pool for testing. If the pool that contains your saliva specimen tests positive for SARS-CoV-2, all specimens in the pool will be individually tested for SARS-CoV-2, because pooled testing does not identify which specimen or specimens were positive.

By registering for COVID-19 testing, you are authorizing Quadrant Laboratories to:

* Use the information that is provided by you or Andover CSD together with the saliva specimen to perform screening or diagnostic testing for SARS-CoV-2. The SARS-CoV-2 testing will be done using Quadrant’s Clarifi COVID-19 Test assay, which has received Emergency Use Authorization from the FDA.
* Store the information that you provide as part of the registration process and your pooled and individual test results in a secure database.
* Release and transmit Your Information to your health care provider, Andover CSD, the New York State Department of Health, and any other federal, state, county, or city health department or agency that is entitled by law to receive the information for public health purposes.
* Release and transmit your Information as necessary to submit claims for payment or reimbursement for any diagnostic tests performed on your saliva specimen to your health insurance carrier, government health program, or any other third party payors you provide information for.

By registering for this testing, you are also authorizing Andover CSD to access the information that you provide through the registration process to schedule and order testing, and to collect saliva specimens to be used in the testing.

This authorization will remain in effect until Andover CSD’s testing program ends.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient’s Parent/Legal Guardian (if minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Legal Guardian (if minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_