Omega Bioservices
Your lab partner in research and diagnosis

COVID19 Testing Consent Form

Patient Information			
Last Name	**First Name**		**MI**
Date of Birth/Age	**Ph #**	**Travel Document #**	
Home Address			
City	**State**	**Zip**	**County**

Informed Consent for COVID-19 Testing

Please carefully read the following informed consent:

a) I consent to COVID-19 testing. If consenting for my child or another person, I certify that I am authorized to provide consent on behalf of the tested person as the person's representative or legal guardian.

b) A sample will be collected by inserting a small swab into both nostrils, or another minimally invasive method. The sample will be tested for the virus that causes COVID-19. The most common risks from a nasal swab are mild pain or discomfort, a little gagging, or a minor nosebleed.

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

d) I understand that I am not creating a patient relationship with Omega Bioservices 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.

g) I certify that the information in this document and any attached documents is true and correct and agree to pay the total costs of this testing.

Patient/Guardian Signature:_____ Date: _____

Relationship to Patient: _____