Fairfield Community Health Center

COVID-19 Rapid Testing

SECTION A: Information About You (PLEASE PRINT)

Name: Last:	First:	Middle Initial:
Date of Birth (MM/DD/YYYY):		**Age:**
Social Security Number:		
Phone Number (Patient or Guardian):		
Can we leave a voicemail message regarding your results? ☐ Yes ☐ No		
Address:		**Apt/Room #:**
City:	**State:**	**Zip:**
County:		
Sex (Gender assigned at birth) ☐ Female ☐ Male		
Race ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ White		
Ethnicity ☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown/Refused to Report		
Are you a current FCHC patient? ☐ Yes ☐ No **If not a current FCHC patient, would you be interested in a staff member following up with you about establishing care with FCHC? (Circle One)** ☐ Yes ☐ No ☐ N/A		

SECTION B – COVID-19 Testing 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, 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 providers, 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 conditions 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. I have been given the opportunity to ask questions before I sign, and have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Signature of Patient/Patient's Representative*:_____ Date:_____

Printed Name:_____ Relationship, if not Patient:_____