Client name: _____ DOB: _____

Consent for COVID 19 testing services and authorization to release confidential information

CONSENT: I understand that Skamania County Community Health (SCCH) requires consent for COVID-19 testing. I hereby give consent and authorize SCCH to administer or direct a COVID-19 test to me. I understand that I have the right to ask questions about my care and any recommended services.

RELEASE: I also understand that in order to properly process the testing kit, I must allow SCCH to share my information with other entities. I understand that in some circumstances, SCCH is required to share some of this information with other government entities, including the Washington State Department of Health. I consent to the sharing of my information in any form including verbal, written, and/or electronic and for my specimen to be handled, including performance of testing, with the following entities:

Washington State Department of Health,
Center for Disease Detection,
Quest Diagnostics and
Any Insurance Provider
My Primary Care Provider if I test positive
ROCK COVE STAFF ONLY: testing date and results will be shared with the Rock Cove Director
Jail Inmates: results will be shared with the Chief—Skamania County Jail

SPECIMENS: I understand that SCCH's only role is to collect the specimens. I understand that SCCH will not be responsible for determining results of the test. A lab will perform the actual analysis of the swab and determine a positive or negative test result. SCCH will notify me of my test result once received from the testing lab.

PAYMENT, INSURANCE: I assign to SCCH and the laboratory the right to bill and collect from any insurance that I have coverage with. I agree to help seek payment from my insurance provider.

CONFIDENTIALITY: I understand services provided and any personal information shared with staff is strictly confidential within the confines of the law. This means that, in general, information may not be revealed to others without my specific written permission (please note permissions above). I understand certain exceptions may apply:

- Certain Communicable Diseases are required by law to be reported to the State Department of Health for public health statistics and follow up*.
- If staff has reason to believe I present an immediate threat of harm to others or myself*.
- If insurance or a third-party payer is used to assist in paying for services, they may require detailed information including a summary of medical history, laboratory or diagnostic tests, information about HIV/AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness or mental health issues.

*(RCW 70.02, 42 CFR Part 2, RCW 71.05, RCW 70.24)

Verbal consent received: Yes_____ No_____

Staff Signature: _____ Date: _____