CONSENT FORM

Please carefully read and provide written acknowledgment of the following informed consent:

1. I authorize a COVID-19 testing administrator and Adam Diagnostic Lab to conduct collection and testing for COVID-19 through a swab collection as ordered by an authorized medical provider or public health official.
2. I authorize my test result, or the test result of my child if my child is under the age of 18 years, to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
4. I give my permission for the county health department to contact me using non-secure methods (email) regarding this COVID-19 test result, and I understand the risks involved.

Signature of Patient: ______________________________
(if client is under age 18 then of parent/guardian)

Date of Birth:

Date of signature: