

## HIPAA AUTHORIZATION FORM

Full Name:	_____		
Date of Birth:	_____		
Parent or Legal Guardian Name:	_____		
Address:	_____		
City:	_____	State: _____	Zip Code: _____
Phone Number:	_____		

I, on behalf of my child or an individual to whom I provide guardianship, authorize Rapid Reliable Testing, LLC ("RRT") along with their medical services provider, MD 1 Medical Care, PC. ("MD 1"), and laboratory partners (together with MD 1, the "Providers") to disclose my COVID-19 test results as between and among themselves and to FRIENDS CENTRAL SCHOOL ("School") with certain limitations listed below.

The **purpose** of this Authorization is to assist School in determining my child's or an individual to whom I provide guardianship's fitness for school during the COVID-19 outbreak. The **specific information that may be disclosed** under this Authorization includes my child's or an individual to whom I provide guardianship's name, contact information and any results of COVID-19 tests performed to School or its affiliates.

**I, on behalf of my child or an individual to whom I provide guardianship, may refuse to sign or may revoke** this Authorization at any time and for any reason. If I, on behalf of my child or an individual to whom I provide guardianship, decline to sign this Authorization, RRT and the Providers may continue to use and disclose my information for all purposes permitted by federal and state law.

My signed Authorization will **remain in effect** until I provide written notice that I, on behalf of my child or an individual to whom I provide guardianship, revoke this Authorization or in one year, whichever comes earlier. I may revoke this Authorization, on behalf of my child or an individual to whom I provide guardianship, by notifying the RRT Privacy Office by phone (347-903-5933), e-mail (compliance@ambulnz.com) or mail (Attention: Rapid Reliable Testing Privacy Officer, 35 West 35<sup>th</sup> Street, 5<sup>th</sup> FL, New York, NY 10001). The revocation will be effective immediately upon receipt of my written notice, except it will not have any effect on any prior action taken by School in reliance on this Authorization. In particular, the revocation will not impact School's, RRT's or a Provider's use or disclosure of health information already contained in my child's or an individual to whom I provide guardianship's employee file, medical staff credentialing file or contractor file.

I understand that once my child's or an individual to whom I provide guardianship's health information has been disclosed to the authorized recipient, the information potentially may be re-disclosed to others who may not be required to abide by this Authorization or who are not subject to the same federal or state laws governing the use and disclosure of my child's or an individual to whom I provide guardianship's health information.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions. By my signature, I authorize, on behalf of my child or an individual to whom I provide guardianship, RRT and the Providers to use or disclose my child's or an individual to whom I provide guardianship's health information in the manner described above.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name

### COVID-19 and IgG Antibody Testing Consent Form

I, \_\_\_\_\_, on behalf of my child or an individual to whom I provide guardianship, authorize a nasopharyngeal swab or nasal swab for COVID-19 Test and/or blood draw for IgG antibody test (collectively, "Specimen Collection") as required by my child's or an individual to whom I provide guardianship's School. I, on behalf of my child or an individual to whom I provide guardianship, further understand, agree, certify, and authorize the following:

1. I understand that my child's or an individual to whom I provide guardianship's Camp has contracted with Rapid Reliable Testing, LLC ("RRT") for collection and testing of my child's or an individual to whom I provide guardianship's specimen (nasopharyngeal or nasal swab and/or blood draw) ("Specimen"). RRT has contracted with MDI Medical Care, PC. ("MDI"), to perform the Specimen Collection, BioReference Laboratories, Phosphorus, Boston Heart Diagnostics, PathMD and Mako Medical Laboratories (collectively with MDI, the "Providers") for laboratory analysis and reporting regarding my child's or an individual to whom I provide guardianship's Specimen.
2. I, on behalf of my child or an individual to whom I provide guardianship, authorize RRT and MDI to perform the Specimen Collection and BioReference Laboratories, Phosphorus, Boston Heart Diagnostics, PathMD and Mako Medical Laboratories to test and report on my child's or an individual to whom I provide guardianship's Specimen as further specified herein.
3. I, on behalf of my child or an individual to whom I provide guardianship, authorize RRT and the Providers to **release the results of my child's or an individual to whom I provide guardianship's test to my child's or an individual to whom I provide guardianship's School.** I, on behalf of my child or an individual to whom I provide guardianship, acknowledge and agree that my child's or an individual to whom I provide guardianship's School may receive my test results before I do. I, on behalf of my child or an individual to whom I provide guardianship, will be able to access my child's or an individual to whom I provide guardianship's test results via a Patient Portal and I will receive Patient Portal access information.
4. I understand that my child or an individual to whom I provide guardianship is not creating a patient relationship with RRT or the Providers by participating in testing. I, on behalf of my child or an individual to whom I provide guardianship, understand none of RRT, the Providers or their personnel are acting as my child's or an individual to whom I provide guardianship's medical provider. Testing does not replace treatment by my child's or an individual to whom I provide guardianship's medical provider. I, on behalf of my child or an individual to whom I provide guardianship, assume complete and full responsibility to take appropriate action with regard to my child's or an individual to whom I provide guardianship's test results. I agree I, on behalf of my child or an individual to whom I provide guardianship, will seek medical advice, care and treatment from my medical provider if my child or an individual to whom I provide guardianship receives a positive test result, is feeling sick, or has any health-related questions or concerns.
5. I, on behalf of my child or an individual to whom I provide guardianship, understand that Specimen processing and results reporting may vary.
6. I, on behalf of my child or an individual to whom I provide guardianship, understand that Specimen Collection via nasal and/or nasopharyngeal may cause bleeding from the nose, I understand that the following conditions put my child or an individual to whom I provide guardianship at a heightened risk for a nosebleed:
  - a. Any history in the past year of nasal surgery.
  - b. Any use of blood thinners, except Aspirin.
  - c. Any nasal trauma within the last month.
  - d. Any known bleeding disorders.
  - e. Any intranasal use of cocaine or other illicit drugs.
7. Negative results do not rule out SARS-Cov-2 infection, particularly in those that have been in contact with the virus. Follow-up testing with a molecular diagnostic should be considered to rule out infection in these individuals. Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-Cov-2 infection or to inform infection status. Positive results may be due to past or present infection with non-SARS-Cov-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E. I, on behalf of my child or an individual to whom I provide guardianship, understand that, as with any medical test, there is the potential for false positive or false negative test results. I, on behalf of my child or an individual to whom I

provide guardianship, agree that, by signing below, I, on behalf of my child or an individual to whom I provide guardianship, am authorizing RRT to acknowledge the above on behalf of my child or an individual to whom I provide guardianship on the clinical laboratories patient portal.

8. I, on behalf of my child or an individual to whom I provide guardianship, recognize that there are certain inherent risks associated with Specimen Collection. I hereby consent for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily agree to have my child's or an individual to whom I provide guardianship's Specimen Collection taken and analyzed by RRT and the Providers, and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my child's or an individual to whom I provide guardianship's participation in this activity, and do hereby release and forever discharge RRT and the Providers, and their employees, agents, representatives, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, economical or emotional loss, that my child or an individual to whom I provide guardianship may suffer as a direct result of their participation in this activity.
9. I, on behalf of my child or an individual to whom I provide guardianship, agree to indemnify and hold harmless RRT, the Providers, and their employees, agents, representatives, successors and assigns, against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me, on behalf of my child or an individual to whom I provide guardianship, or anyone on my behalf, including reasonable attorney's fees and any related costs, if litigation arises pursuant to any claims made by my child or an individual to whom I provide guardianship or by anyone else acting on their behalf.

I, on behalf of my child or an individual to whom I provide guardianship, acknowledge that I have read, understand, agree, certify, and/or authorize the information above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child

