STATE OF NEW HAMPSHIRE
COVID-19 TESTING
CONSENT FORM

I _____, [Undersigned's Name Printed] authorize the Metropolitan Medical Reserve System/New Hampshire National Guard/Home Health entity, or [Name of Authorized Entity]_____to administer, and for the New Hampshire National Guard/New Hampshire Department of Health and Human Services, Public Health Laboratory/Quest Diagnostics/Lab Corps/Dartmouth Hitchcock, or [Name of Authorized Processing Entity]_____to process a nasopharyngeal or oropharyngeal swab for a COVID-19 Test, as ordered by a medical doctor, the state epidemiologist, or authorized health care provider,_____[Name of Ordering Individual]. I further understand, agree, certify, and authorize the following:

1. I am a resident of the state of New Hampshire, or I am the parent or legal guardian (if the undersigned is a minor or dependent) of the patient named above.

2. I understand that this testing is voluntary and that I have the right to refuse this test.

3. I have a valid prescription for this testing or a laboratory order from a licensed New Hampshire physician, the state of New Hampshire epidemiologist, or an authorized healthcare provider.

4. I understand that the sample I provide might produce a false positive or negative.

5. I understand that I have a right to view my test result and a right to discuss my results and any treatment, precautions, and quarantine if so necessary, required for my health and safety and the safety of my family and the community, with my healthcare provider.

6. I understand that a positive test result is required by RSA 141-C:7 and RSA 141-C:8 to be shared with the New Hampshire Department of Health and Human Services, Division of Public Health.

7. I authorize the test results to be shared with the Authorized Processing Entity processing the sample, the New Hampshire Department of Health and Human Services, Department of Public Health Services, and the healthcare provider ordering the test named above.

8. I authorize and understand that my test result may be shared with my manager at_____[Name of Employer] and any positive test will be shared in accordance with RSA 141-C:10 and He-P 301.08.

9. I further authorize and understand that my test result may be shared with the following entity _____with my express permission as indicated here _____[Undersigned's Initials].

10. I understand that the results of my test will otherwise remain confidential as allowed under state and federal law.

11. I understand that this consent will remain in effect for one (1) year from the date of signing unless specifically revoked in writing by the Undersigned before the end of one (1) year.

12. I have read, agree to, and understand this Consent Form. I authorize disclosure of my medical information as described above. Further, I agree to hold harmless the State of New Hampshire; New Hampshire National Guard; Department of Health and Human Services, Public Health Laboratory; the Metropolitan Medical Response System; Home Health entity; and any other entity administering this test, including its employees, agents and contractors from any and all liability claims.

Date:_____ Signed:_____
[Individual/Undersigned/Legal Guardian*]
[* Required authorizing guardianship paperwork must be attached to this Consent.]
Date:_____ Witness Signature:_____ Witness Printed Name:_____