AUTHORIZATION AND INFORMED CONSENT FORM

SCHOOL: St. Clare School **Address:** 151 Lindenwood Rd. **Phone Number:** (718) 984-7091

STUDENT or STAFF MEMBER TO BE TESTED:		
Name of Individual to be Tested	**Date of Birth**	**Date of Service**
Tested Individuals Address	**Student/Staff ID**	**Notes or Concerns:**
LEGAL REPRESENTATIVE OF STUDENT:		
Name of Student's Legal Representative	**Relationship to Student**	**Home Telephone Number-Legal Representative**
Legal Representative Address	**Cell Phone Number – Legal Representative**	**E-Mail Address - Legal Representative**
TESTED INDIVIDUALS PRIMARY PHYSICIAN:		
Name of Primary Physician	**Telephone Number-Primary Physician**	**Address of Primary Physician**
INSURANCE:		
Health Insurance: Insurer:	**Health Plan/Group Number:**	**Health Insurance Member ID Number:**

I, _____, am the legal representative for the Student named above ("Student") and either on Student's behalf or for myself if I am eighteen years of age or older hereby authorize **PHYSICIANS OF THE FUTURE MEDGROUP, PLLC DBA RAPID CARE SOLUTIONS** ("PLLC") to perform the Service listed below for Student or myself as requested by the School identified above ("SCHOOL").

SERVICES: **Collection of Specimen for COVID-19 Testing**

As a condition of PLLC providing the Services to the Student, or on behalf of myself, I make the following statements as the Student's legal representative or on my own behalf if I am to be tested: I have the legal right and authority to represent Student or myself in connection with this authorization and consent and the Services to be provided hereunder. I authorize PLLC to perform the Service selected above. I authorize PLLC to: (i) collect one or more specimen and arrange for testing for COVID-19, in the manner appropriate for such Service, which includes a nasopharyngeal swab; (ii) send such specimen collected to a laboratory that is acceptable by this state; (iii) obtain all test results for such Service ("Test Results"); (iv) contact me at my telephone number(s), email or address provided above regarding the Test Results and advise me of the need for follow-up medical care for Student or myself from Student's or my primary physician; (v) notify the SCHOOL of the Test Results and confirm that the Service has been performed for Student or myself; (vi) send or arrange for the transmission of the Test Results to Student's or my primary physician who is identified above; (vii) if there is a positive Test Result, contact me following transmission of such result to advise me that it is my responsibility to obtain further medical care for myself or for the Student from Student's primary physician if appropriate, and that if I or Student does not have a primary physician, to seek follow-up medical care for myself or Student from another physician of my choice and to cause myself or the Student to follow any quarantine/isolation requirements that may be necessary; and (viii) submit claim for the Service to the health insurance plan identified above, if appropriate. I authorize the Test Results of Student or myself to be reported to the SCHOOL and to the state and local health departments and any other governmental or regulatory entity that may be required and to report any demographic or other personally identifiable information about me that is required to the applicable department of health and/or other regulatory entity as may be required by applicable law, regulation or order.

I acknowledge that: (i) I have been informed about the purpose, procedures, possible benefits and risks of the Service hereunder and I have received a copy of this Authorization and Informed Consent Form; (ii) the information contained in this Authorization and Informed Consent Form is accurate and correct; (iii) a positive Test Result for COVID-19 is an indication that I or the Student will have to self-isolate in an effort to avoid infecting others; (iv) the Test Results or information disclosed pursuant to this authorization may be subject to re-disclosure; (v) as with any medical test, there is the potential for false positive or false negative test results; (vi) I have been advised that testing for COVID-19 is voluntary; (vii) a physician/patient relationship between Student or myself and PLLC is NOT being created by participation of receiving the Service hereunder; (viii) PLLC is not acting as my or the Student's medical provider with respect to the

Please Sign Other Side

Service hereunder and testing does not replace treatment by Student's or my medical provider; (ix) I assume complete and full responsibility to take appropriate action with regards to the Test Results and I agree that I will arrange for medical advice, care and treatment for myself or Student from Student's or my medical provider if the test yields a positive Covid-19 Test Result; and (x) I have been given a copy of PLLC's Notice of Privacy Policy on behalf of Student and myself.

On behalf of myself and Student, I release PLLC and SCHOOL, and their respective shareholders, owners, partners, members, managers, executives, officers, directors, employees, independent contractors, principals, agents, subsidiaries, successors, affiliates, related entities, assigns, insurers, attorneys, trustees, administrators, and other representatives, both individually and collectively, from all liability and claims whatsoever pertaining to the Service rendered by PLLC hereunder and any disclosure or release of any information related to such Service described in this Authorization and Informed Consent Form.

This authorization and informed consent constitutes an express waiver of any rule against disclosure that may otherwise be provided by any confidentiality law or other provision of federal, state or other applicable law, including but not limited to the Health Insurance Portability and Accountability Act, and the Health Information Technology for Economic and Clinical Health Act, and the regulations thereunder.

I certify that I am 18 years of age or older and have read and fully understand the contents of this Authorization and Informed Consent Form, that I have been given the opportunity to ask questions and that my questions have been answered, and that I am signing this Authorization and Informed Consent Form voluntarily. I authorize and agree that a photocopy or electronic copy of this Authorization and Informed Consent Form may be accepted with the same authority as the original, and that a copy may be given by PLLC to the SCHOOL. By signing below, I acknowledge having had adequate time and opportunity to fully consider this authorization and consent and I agree to all of the terms and conditions herein.

ONLY ONE OF THE FOLLOWING SECTIONS MUST BE COMPLETED

This Section to be completed if authorization and informed consent is given by a LEGAL REPRESENTATIVE of the STUDENT.

_____ _____

Name of Legal Representative of Student (Print) Signature of Legal Representative of Student

_____ _____

Name of STUDENT Description of Authority to act as Legal Representative of STUDENT (e.g., Legal Guardian, Attorney-in-Fact, etc.)

Date Signed:_____

This Section to be completed if authorization and informed consent is given by the STUDENT who is age 18 or over.

_____ _____

Name of STUDENT or Staff Member (Print) Signature of STUDENT or Staff Member

Date Signed:_____