PUREVIEW Health Center

COMMUNITY COVID-19 CLINIC - CONSENT AND REGISTRATION FORM

Client Information (please print legibly)

Full Name			Sex
Street Address	City	State	Zip
Phone Number		Date of Birth (mm/dd/yy)	
Primary Care Provider			

1. I am the: ☐ individual ☐ parent ☐ legal guardian of the individual named below.

2. I authorize the Montana Department of Public Health and Human Service (DPHHS) and PureView to perform testing on my (or my dependent's) specimen.

3. I understand that processing the specimen and results may take up to one week.

4. I understand my (child's/dependent's) test results will be disclosed to the county and state health entity as required by law. Results will also be disclosed to PureView to allow PureView staff to notify patients of the results.

5. I acknowledge that a positive test result is an indication that I (my child / dependent) may be required to isolate to avoid infecting others. Should the test result be positive, I (my child / dependent) will be contacted by local public health with further instruction. Negative results will be communicated using a variety of channels to include but not limited to: phone, mail, electronic/web-based delivery, or other reasonable means.

6. I understand that a patient relationship with DPHHS or PureView is not created by participating in testing. I understand the testing unit is not acting as my or (my child's/dependent's) medical provider. Testing does not replace treatment by a medical provider. I will take appropriate action with regards to my (child's/dependent's) test results. I will seek medical advice, care and treatment from my (child's/dependent's) medical provider with questions or concerns, or if a health condition worsens.

7. I hereby consent for myself (child/dependent), my (child's/dependent's) heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily agree to have my sample taken and analyzed and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my participation in this activity, and do hereby release and forever discharge DPHHS and its agents for any injury that I may suffer as a direct result of my participation in this activity, including traveling to and from any location related to this activity.

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Printed Patient Name **Patient DOB**

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Patient/Parent/Legal Representative Signature **Date**