RiverStone Health
Connecting you to a better life

COVID-19 TESTING PATIENT CONSENT

STAFF USE ONLY
Symptomatic: Yes ☐ No ☐

Close Contact: Yes ☐ No ☐

Please Print Neatly/ Fill in All Blanks/Leave Consent Form at the Testing Site

Name (of person being tested):_____ **DOB**:_____

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Phone Number: ( )_____ **Email:**_____

1. I am the: ❑ Person to be tested ❑ Parent ❑ Legal Guardian
2. I authorize RiverStone Health to collect a nasal specimen for COVID-19 testing.
3. I authorize the Montana Department of Public Health and Human Service (DPHHS) Lab to process and result the COVID-19 test on the collected specimen.
4. I understand that processing the specimen and receiving test results may take awhile.
5. I understand that DPHHS will release the results of my test to RiverStone Health and to local and state health departments as required by law.
6. I acknowledge that a positive test result is an indication that I (my child / dependent) may be required to isolate to avoid infecting others. In addition, all members of my household and close contacts may be required to be quarantined. Should the test result be positive, I (my child / dependent) will be contacted by local public health with further instruction which could include further testing.
7. I understand that negative results will be confidentially communicated utilizing a variety of channels to include but not be limited to: phone, mail, electronic delivery or other reasonable means.
8. I understand that a patient relationship with DPHHS is not created by participating in testing. I understand RiverStone Health 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.
9. 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 RiverStone Health 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.

_____ _____

Printed Name of Person Being Tested **Printed Name of Parent/Legal Guardian**

_____ _____

Patient Signature (**If under age 18, parent or legal guardian must sign**) **Date**