ResourcePath

COVID-19 TESTING CONSENT & RELEASE OF INFORMATION FORM

The Arlington Public Schools testing program includes testing of individuals with symptoms or exposures as well as random surveillance testing. At this time, ResourcePath's testing is limited to identifying current SARS-2-CoV infection (also known as COVID-19 or 2019 Novel Coronavirus) using nucleic acid amplification. This tests are not designed to identify previous infection. With this consent form we are asking for your permission to perform mid-nasal swab testing with the purpose of detecting active COVID-19 infection.

Results: ResourcePath will perform the testing and provide you with results. Results will be e-mailed to you at the e-mail address listed on your intake form. We will call you if the result is positive. It is your responsibility to share results with you/your child's physician. With your consent by signing this form, you agree to let ResourcePath also notify yours/your child's school of your test results for infection control and public health purposes.

Payment: ResourcePath will bill insurance if insurance information is provided. The Arlington Public School will pay for testing for uninsured individuals and in other patients for which insurance does not cover the testing. You will not be liable for any payments for testing through this program.

1. CONSENT FOR TREATMENT. This is to certify that I consent to and authorize ResourcePath and/or school contract staff to collect a sample from me/my child for COVID-19 testing, or to instruct me/he/she in how to self-collect a sample. I authorize ResourcePath to release my or my child's results to me via mail, and if positive, by contacting me at my emergency contact phone number and leaving a message. In the event of any positive COVID-19 result, I understand that ResourcePath is required by law to report my test result to the local health department.

   I understand that ResourcePath is not acting as my or my child's doctor, that this does not replace treatment by a physician and that I assume complete and full responsibility to take appropriate action with regard to test results, up to and including consulting with a physician. In this regard, I do not and will not hold ResourcePath responsible for my test results and absolve them of any liability. I agree that I will seek medical advice, care and treatment from my or my child's usual source of health care if I have questions or concerns, have any symptoms of illness, or become ill. In the event of an accidental blood/body fluid exposure to a ResourcePath staff member involved in the collection or processing of the sample(s), I consent to any routine blood or other tests deemed necessary for the safety of the staff. As with medical testing of any nature, the potential for falsely elevated, lowered, positive or negative laboratory values is present.

2. AUTHORIZATION, FOR RELEASE OF INFORMATION. I understand that the school district will be facilitating sample collection for students who may have symptoms arising at school and/or as part of random surveillance testing performed at all the schools in the district. The goal of testing for students/staff/families with symptoms is to make it easier on families to be tested conveniently with results provided quickly. The goal of surveillance testing is to provide important information about student/staff infection rates which can guide additional protection measures if needed. I authorize ResourcePath to utilize confidential medical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes, or as required by law. I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed testing and not with respect to testing that has already been performed. With the exception of school notification of results, I understand that all other applicable confidentiality protections shall apply to the services I receive. I understand that I shall have access to all medical information resulting from the testing provided.

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HIPAA EMAIL CONSENT - VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act.*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted. ResourcePath uses a business class email product hosted by Hushmail or Citrix that encrypts email and your health information in its systems and while it is in transit to you.
- Most popular email services that you might use for your *personal* email (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, the information that is sent is encrypted by default (unless you request otherwise). In spite of this, a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest update to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website:
  https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of receiving health information by email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal health information via unencrypted email

ACKNOWLEDGMENT

- By signing below, I affirm that I have read the Testing Consent, HIPAA release to School & Request Form and by signing I understand and agree to what it says.

- By signing below, I acknowledge that I have received a copy of ResourcePath's "Notice of Privacy Practices."

- By signing and providing an email address below, I acknowledge that I understand the risks of receiving health information by email and do hereby give permission to ResourcePath to send me an electronic copy of its Notice of Privacy Practices and personal health information via email.

_____
Name of Person Being Tested

_____ _____
Name of Person Providing Consent to Testing (Print) **Relation to Person Being Tested**

_____
Name (Sign) **Date**

_____
Emergency Phone Number

☐ I request ResourcePath send me lab results via unencrypted email

For Internal Use Only:
Reason Acknowledgment was not obtained:

_____
Name (Sign) Date

_____
Name (Print)