HEARTFIT FOR DUTY

Protecting our First Responders

COVID-19 TESTING FORM

PATIENT NAME: _____

STREET ADDRESS: _____

(CITY) _____ (STATE) _____ (ZIP) _____

EMAIL ADDRESS: _____

CELL PHONE: (___) ____-_____

DATE OF BIRTH (MM/DD/YYYY): ____/____/_____ AGE:_____ GENDER:_____

CONSENT FOR TREATMENT/ HIPAA RELEASE

I give permission for HeartFit For Duty Medical staff to perform a COVID-19 test on me. The testing process has been explained to me and I have had an opportunity to ask any questions I may have. I acknowledge that HeartFit For Duty cannot guarantee the accuracy of the result and that it may be necessary for me to undergo additional testing in the future. I recognize that even if I have a negative result now, I can still contract COVID-19 in the future. Administering the test does not create a patient/physician relationship between me and HeartFit For Duty or any of its employees, nor does it obligate HeartFit For Duty or its staff to perform any other care or treatment for me. I authorize HeartFit For Duty to receive my test results and convey them to me. I understand by undergoing the test HeartFit For Duty may have to report the results to the Department of Health or other mandatory reporting agencies.

Signature: _____ Date: _____