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COVID-19 INFORMED CONSENT

[Name of Practice] prioritizes the health and wellbeing of our patients and staff. To meet this objective, we have implemented changes to our operations, protocols and procedures in light of the coronavirus ("COVID-19").

Despite the precautions that we are taking to reduce the risk of infection of COVID-19, it is important for you to recognize the risk of exposure to COVID-19 when you are in our office.

It is also important for you to know that [Name of Practice] **[chose one]** [is not testing patients for COVID-19 who are suspected of having COVID-19 and is not treating confirmed COVID-19 patients] [is testing patients for COVID-19 who are suspected to have COVID-19, but we are not treating confirmed COVID-19 patients] [is testing patients for COVID-19 who are suspected to have COVID-19 and are treating COVID-19 patients].

[Name of Practice] has taken precautions with regard to COVID-19 such as, among other things, routine cleaning of exam rooms and common areas, such as waiting rooms, implemented screening procedures for patients who are scheduled for in-person visits, implemented screening procedures for staff, have a policy of social distancing of staff and patients while at the office, and [have designated exam rooms and separate waiting rooms].

Despite taking these precautions, there are no guarantees that these precautions will prevent you from coming into contact with COVID-19 and contracting COVID-19 at the office if you have an in-person appointment. As a result, by having an in-person office appointment, you understand and acknowledge that you assume the risk of coming into contact and contracting COVID-19.

You understand and acknowledge that contracting COVID-19 may result in, among other things, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, stroke and death.

You understand and acknowledge that high risk patients are at a higher risk of death, stroke, and/or prolonged hospitalization, intensive care treatment, intubation/ventilator support or other prolonged illness in the event that high risk patients become infected with COVID-19. High-Risk COVID-19 patients include, among others: (1) 65 years old or older; (2) patients, regardless of age, with lung disease (COPD, asthma, pulmonary hypertension, pulmonary fibrosis, cystic fibrosis, oxygen dependent, etc.); (3) patients, regardless of age, with heart disease (heart attack/stent/bypass surgery in the past six months, history of congestive heart failure, etc.); (4) patients, regardless of age, with diabetes mellitus; (5) patients, regardless of age, with immunosuppression or those taking immunocompromising medications.

Just as important, if you are not at high risk of COVID-19, you are still at risk of harm from COVID-19 as explained above. You understand and acknowledge that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein.

Based on the discussion you had with [Name of Practice], you understand and acknowledge the risks and prognosis if no treatment is received or if you delay your appointment. You have been given the option to defer your appointment to a later date. Even though you understand all the potential risks including, but not limited to, the potential short-term and long-term complications related to COVID-19, you would like to proceed with your in-person appointment.

I believe that I have adequate knowledge upon which to base an informed consent to have an in-person visit to [Name of Practice]. I certify that I have read and fully understand the above and that the explanations referenced above were made to me. I acknowledge that I have been afforded the opportunity to ask any questions including the risks and consequences. My questions, if any, have been answered to my satisfaction and I have no further questions. I have read and fully understand this form, and I represent that I am signing this consent voluntarily and intend to be legally bound by it.

_____ _____
Signature of Witness Signature of Patient

_____ _____
Signature of Primary Physician Date

When a patient is a minor or incompetent to give consent, complete the following:

The patient named above is not able to give consent because: _____

_____

Signature of Authorized Agent: _____

Relationship to Patient: _____ Date: _____

Signature of Witness: _____

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AUTHORIZATION TO RELEASE COVID-19 TEST RESULTS

- I, _____, authorize [Name of Practice] to release and disclose my COVID-19 test results to anyone at the [Name of Practice] who came into contact with me during my in-person visit in the past thirty days.
- I also authorize [Name of Practice] to release and disclose my COVID-19 test results to the New Jersey Department of Health and/or any other public agency to whom [Name of Practice] is required to provide such information as well as my protected health information, which includes demographic information, as that term is defined under 45 CFR 160.103.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that the individual or entity receiving my medical records and/or information pursuant to this authorization may use or disclose the medical records and/or information to third parties.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

PATIENT _____ DATE _____

PARENT OR LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____