COVID-19 Specimen Collection Clinic Form

Section A: Demographic Information

NAME (Last)	(First)		(M.I.)
MAILING ADDRESS			
CITY	STATE	ZIP	
DATE OF BIRTH _______/_______/_______ Month / Day / Year	PHONE NUMBER		
LOCATION OF CLINIC/SPECIMEN COLLECTION:			

Section B: Information about Specimen Collection

For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing an upper respiratory specimen through anterior nares nasal swab specimen collection.

Anterior nares nasal swab is done by gently inserting a swab into the nostril at least 1 cm (0.5 inch) and firmly sample the nasal membrane by rotating the swab and leaving in place for 10 to 15 seconds. Then gently removing the swab and doing specimen collection in the other nostril with the same swab.

Section C: Information about Sharing Personal Health Information

As part of the testing process, I understand and accept, for myself and/or for a minor under 18 and/or legal ward, that my personal health information (my name, date of birth, test sample and test result) will be shared with third parties outside the Vermont Department of Health (CIC Health, CareEvolve and Ellkay) solely for the purposes of processing my sample, evaluation and authorization of tests, if appropriate, and providing me and the Department of Health with the results. The Department of Health and these third parties all comply with the requirements of state and federal privacy laws for the protection of personal health information, including HIPAA, and use will use commercially reasonable best efforts to not disclose any individually identifiable health information, except for the following circumstances: in case of emergency; for the purposes of contact tracing; to inform others about their risks and otherwise as permitted or required by law.

I also acknowledge that I have been offered information about the State of Vermont's privacy notice [Link] and the specific privacy policies of the third parties [Link]. I further understand agree that my personal health information may be used, in a deidentified format, for any appropriate research purpose to enhance human understanding of SARS-CoV2 and/or COVID19, to develop diagnostics, treatments, and promote scientific or engineering advances, without limitation.

If you have questions, please contact: margaret.robinson@vermont.gov or ask the person who gave you this form.

Section D: Consent

By signing below, I agree to the following:

- I have reviewed the information on how a COVID-19 specimen collection is performed and how my health information will be shared and protected.
- I have had the opportunity to ask questions.
- I give my consent for the Vermont Department of Health and associated third-parties (CIC Health) to perform specimen collection and to take necessary steps for the subsequent testing of that specimen for COVID-19.
- I understand and consent to certain necessary sharing of my health information with third parties (CIC Health, ixLayer) for the purposes of medical diagnosis and protecting public health (including genomic sequencing of the virus using de-identified specimens).
- I have had the opportunity to review the privacy notice of the Department of Health and the privacy policies of the third parties and accept their terms.

Name: ____

Signature: ________________________________ **Date:**___/____/_____

If Individual to be tested is under 18 years of age:

Name of Parent/Legal Guardian:

____

*If minor is in state custody, an authorized representative signature is required.

Parent/Legal Guardian Signature:

____ **Date:** ___/____/____

*If minor is in state custody, an authorized representative signature is required.

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Name, Title and Signature of Healthcare Professional Collecting Specimen:

Type of Specimen Collection Performed: ☐ NP ☐ Nasal

______________________________ ______________________________

Name (Print) Title/Credentials

______________________________ Date: ___/____/____

Signature