COVID – 19 TESTING REQUEST FORM

WWW.MEDSTARLAB.COM

4531 W. Harrison St.
Hillside, IL 60067
708-488-1000

REPORTER INFORMATION

DATE: _____ DIAGNOSIS CODE: _____ ACCOUNT # 1429

PHYSICIAN'S FIRST NAME _____ PHYSICIAN'S LAST NAME _____

PHYSICIAN'S SIGNATURE: _____

PATIENT INFORMATION

BIRTHDATE: ☐☐ ☐☐ ☐☐☐☐ SEX: F ☐ M ☐

FIRST NAME: LAST NAME:

STREET ADDRESS: (Include Apartment / Suite Number)

CITY: _____ STATE: ☐☐ ZIP CODE: ☐☐☐☐☐

EMAIL: _____ PHONE NUMBER: _____

INSURANCE INFORMATION

MEDICARE # _____ NO INSURANCE: ☐ INITIAL: _____

PRIVATE INSURANCE NAME: _____

POLICY ID: _____ GROUP ID: _____

CLINICAL INFORMATION

Does the patient have underlying conditions?

- ☐ None
- ☐ Unknown
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cardiac Disease
- ☐ Immunocompromised
- ☐ Pregnant
- ☐ Chronic Lung Disease
- ☐ Chronic Liver Disease
- ☐ Other

SYMPTOMS: Check symptoms you currently have:

- ☐ Fever
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Headaches
- ☐ Body Aches
- ☐ Loss of Taste or Smell

SYMPTOM ONSET DATE: _____

RECENT TRAVEL: _____

TEST INFORMATION

DATE COLLECTED: _____ TIME COLLECTED: _____ AM / PM

PATIENT'S SIGNATURE: _____ DATE: _____

DISCLAIMER

In consideration for receiving the opportunity to participate in COVID-19 testing (hereinafter "Testing"), which is provided by Rapid Screening LLC, (the Company), hereby release, waive, discharge, covenant not to sue, and agree to hold harmless for any and all purposes Company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees (herein referred to as "indemnitees") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in Testing, while traveling to and from the Testing, or while on the premises owned or leased by Indemnitees.

I am fully aware that the Testing provided by Company may involve COVID-19 tests that have not gone through a full FDA approval process and instead obtained emergency use authorization (EUA) or registered and are pending such processing and that the results could produce false positives or false negatives, or be administered in a way that otherwise produces inaccurate results. I am also fully aware that the Company is not providing medical care or giving a medical diagnosis with Testing and that I should consult my doctor or go to an emergency room if I have a serious symptom and/or to obtain medical advice from my own doctor as to the results of the Testing.

I hereby waive my rights regarding protected health information under HIPAA, to the extent necessary to complete the Testing and to allow Company to provide the results (whether positive or negative) of Testing to (1) the organization which has arranged for the testing, and (2) local and state public health authorities (which may result in further direct communication from those entities to me for further follow-up and contact tracing). Protected health information will not be reused or disclosed by Company to any person or entity other than above, except as required by law.

By signing below, I am agreeing to voluntarily testing. In signing this agreement, I acknowledge and represent that I have read it. understand it, and sign it voluntarily.

_____

Signature or Parent/Legal Guardian

(if Participant is under 18 years old, please have Parent or Legal Guardian Sign)