Northwestern Medicine®

COVID-19 TESTING AND DIAGNOSTIC SERVICES FOR NORTHWESTERN UNIVERSITY EMPLOYEES AND STUDENTS

Employee/Student Name: _____ **Birth Date:** _____

Employer/School: **Northwestern University**

CONSENT FOR TESTING AND DIAGNOSIS (NU STUDENT OR NU EMPLOYEE}

Please read carefully the following informed consent:

1. I consent to testing and diagnosis for COVID-19 by Northwestern Memorial HealthCare clinical affiliates and their physicians, employees, or designees, or an independent laboratory acting on their behalf (collectively, "NMHC").

2. I understand that by signing this document and agreeing to undergo testing and diagnosis for Covid-19 testing that I am not creating a treatment relationship with the ordering physician. Testing does not replace treatment by my medical provider. I agree I will seek medical advice, care and treatment from my medical provider if I receive a positive diagnosis from my Covid-19 testing.

3. I have read and understand this consent to testing and diagnosis for COVID-19. I have been given an opportunity to ask questions and have no remaining questions at this time.

4. I acknowledge that I have been provided a copy of the Northwestern Memorial HealthCare Notice of Privacy Practices, which I may review at nm.org.

_____
Patient or Patient's Legal Representative Signature

AUTHORIZATION TO RELEASE INFORMATION

I authorize Northwestern Memorial HealthCare and its clinical affiliates or an independent laboratory acting on their behalf (collectively "NMHC") to **disclose my identifiable health information related to my COVID-19 testing and diagnosis to My Employer or My School** listed above. The purpose of the disclosure is to assist **My Employer or My School** in accessing and evaluating my Covid-19 results for follow-up purposes, including quarantine, exposure evaluation, and contact tracing purposes.

My Employer or My School has requested that NMHC provide testing and diagnosis for Covid-19 to me so that the information may be shared with **My Employer or My School**. I understand that my refusal to sign this form means that NMHC will not render such testing and diagnosis for Covid-19 on behalf of **My Employer or My School**. Otherwise, NMHC may not condition my testing, diagnosis or treatment on signing this authorization. I also understand that once NMHC releases my identifiable health information, federal and state privacy laws may not protect the information, and the entity receiving my information may re-disclose it.

This Authorization to Release Information will be valid for four years from the date of my signature. If I change my mind and no longer wish for my identifiable health information related to my COVID-19 testing and diagnosis to be shared with **My Employer or My School**, I must let NMHC know in writing by contacting the NMHC Medical Records Department (contact information set forth below). NMHC clinical affiliates will then no longer share my identifiable health information related to my COVID-19 testing and diagnosis with **My Employer or My School** (although NMHC will not be able to take back any disclosures that it made while this authorization was in effect), and NMHC may inform **My Employer** or **My School** of such election.

_____
Patient or Patient's Legal Representative Signature

Date:_____

25 North Winfield Road
Winfield, Illinois 60190
Fax: 312-926-3093
Phone: 877-973-2673