



# COVID-19 Testing: Long-Term Care Staff and Resident Consent Form

Test Site Name: \_\_\_\_\_

Date: \_\_\_\_\_

COVID-19 is an infectious illness caused by a newly discovered coronavirus. For many, the illness is mild or does not produce symptoms; however, the elderly and those with underlying medical problems (such as heart disease, diabetes, chronic respiratory disease, and cancer) are more likely to develop a serious illness that may result in hospitalization or even death. We, the Minnesota Department of Health (MDH), are offering you a COVID-19 test because you work or reside in a long-term care facility where residents may be at risk of serious illness.

## Privacy Notice

We are collecting your test sample and other information to determine if you have COVID-19 and to provide you with information on your results. You are not legally required to provide this data, but if you do not provide this information, we cannot test you. The only people who will have access to private information, such as your name and medical information, will be the laboratory conducting the test, your insurance provider, public health staff from the Minnesota Department of Health, local public health, or their contractors to conduct disease investigations or other public health activities, or other persons or entities authorized by law.

## Consent

Through your signature below, you certify that you have read and understood the attached *COVID-19 Post-Test Instructions*, and that you have had the opportunity to ask questions about the test. You have also been informed of the risks and benefits associated with the test, including the possibility of slight discomfort in the nose or throat, bleeding from the nose, or an incorrect result. If you undergo testing, you acknowledge that you did so voluntarily. If you decline testing, you understand that you may carry or transmit COVID-19, even if you do not have symptoms.

You also understand that **your records** are protected under State and Federal privacy laws and cannot be disclosed without your written consent, unless otherwise provided by law. By providing your consent to be tested, you authorize your information and test results to be shared as described in the above Privacy Notice.

\_\_\_\_\_ (initial) I hereby **give my permission/consent** to have a test sample taken.

In addition, your facility would also like your test results so it can take precautions to protect you, staff, and residents. You may choose not to share your results with your facility, but this refusal may impact your ability to work if you are staff, or to participate in certain activities or access areas of the facility if you are a resident.

\_\_\_\_\_ (initial) I hereby **give my permission/consent** for my facility to receive my test results.

<b>SIGNATURE</b> – Staff or Resident:	Print:	Date (mm/dd/yyyy):
<b>SIGNATURE</b> – Parent or Guardian:	Print:	Date (mm/dd/yyyy):

**DISCLAIMER FOR FACILITIES AND PROVIDERS:** MDH is not your attorney. Facilities or providers that order testing for their staff and residents directly and that use this form as a template or example do so with no guarantee that it will serve their needs or relieve them of legal liability.