Consent Form

COVID-19 Testing

To maintain the health and safety of its students and employees in connection with the COVID-19 public health emergency, Emory University ("Emory"), has arranged for Peachtree Immediate Care ("Peachtree") to administer COVID-19 virus testing to students and staff via nasal swab and/or blood specimen collection. Peachtree also may, but is not obligated to, conduct follow-up COVID-19 testing.

I consent to the COVID-19 testing and collection of my personally identifiable information and medical information, including without limitation, COVID-19 test result (referred to as my "Information"). I consent to Emory's release and disclosure of my Information to Peachtree. I understand Peachtree will disclose my Information to Emory, including without limitation, certain Emory management-level employees and human resources department employees of Emory on a need to know basis, and I consent to that disclosure. I also consent to Peachtree and Emory sending my test specimen sample and Information to LabCorp or other third-party laboratory, for testing and diagnostic purposes. I consent to disclosures of my Information by Peachtree, LabCorp (or other third-party laboratory) and Emory to public health oversight agencies and governing bodies as required. I understand that Peachtree, LabCorp (or other third-party laboratory) and Emory will maintain a record containing my Information as required by law and I consent to such record storage.

Peachtree will provide me with my test results and I understand that I am responsible for providing my test results to my treating healthcare providers. Peachtree or Emory are not responsible for medical care or treatment or any follow-up testing.

I hereby release any and all claims under any applicable local, state, or federal law relating to COVID-19 testing by Peachtree, LabCorp and Emory and disclosure of my COVID-19 test results and other medical information by Peachtree, LabCorp and Emory.

If the student is under 18 years old, this consent form must be signed by the student's parent or legal guardian on behalf of the student.

I understand that I may print this signed consent form for my files or upon request I can receive a copy.

Patient's Name: _____

Patient's Date of Birth: _____ /_____ /_____

Patient's Signature (if over 18 years old) _____

Date: _____ /_____ /_____

By signing below, I verify that I am the parent or legal guardian of this student.

If patient is under 18 years old, please complete the following:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

PEACHTREE IMMEDIATE CARE
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EMORY HEALTHCARE NETWORK