Athletic Authorization and Consent

for COVID-19 Diagnostic Testing

I voluntarily consent and authorize CUUR Diagnostics ("CUUR") to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test ("Test"). I acknowledge and understand that my Test will require the collection of an appropriate sample by a healthcare provider through a nasopharyngeal swab, oral swab or other recommended and accepted collection procedure. I understand and assume the inherent risks and discomfort associated with the Test, including, gagging and nosebleed. I understand there are benefits associated with undergoing a diagnostic test for COVID-19, but acknowledge the possibility of a false positive or false negative test result. I assume and accept l responsibility to take appropriate action as recommended by the Center for Disease Control and any applicable health department, administrative agency or consulted physician, with regards to my actions after receiving my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek medical advice and treatment.

Notice of Privacy Practices and Patient Rights: I understand that CUUR follows all federal and local laws and regulations, including the Health Insurance Portability and Accountability Act. I understand that this Authorization and Consent allows CUUR to use private health information for treatment and payment. I agree that CUUR may use de-identified health information about me for approved research and quality improvement activities. For more detailed information, please review CUUR's Notice of Privacy Practices, which describes how CUUR may use and disclose your protected health information to carry out treatment, initiate and obtain payment, conduct health care operations and for other purposes that are permitted or required by law. To review a copy of your rights as a patient and CUUR's Notice of Privacy Practices please check.

_____ I acknowledge that CUUR has offered to provide me with a copy of CUUR Diagnostics Notice of Privacy and Practices.

Disclosure to Government Authorities: I acknowledge and agree that CUUR may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted or required by law.

Release

To the fullest extent permitted by law, I hereby release, discharge and hold CUUR harmless, including, without limitation, any its respective officers, directors, members, managers, employees, contractors, representatives and agents, from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

I acknowledge that I have read, understand and agree to the statements contained within this Authorization and Consent. I have been informed about the purpose of the Test, procedures to be performed, potential risks and benefits and associated costs. I have been provided an

opportunity to ask questions before proceeding with the Test and I understand that if I do not wish to continue with the collection, testing or analysis of the Test, I may refuse the Test or decline to receive continued services.

I have read this Authorization and Consent in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19. I understand I can cancel this Authorization and Consent in writing and/or limit release of medical records if I notify CUUR in writing to cancel this Authorization and Consent and release.

Print Name: _____

Signature: _____

Date: _____

DOB: _____

☐ Agree & continue

Please accept consent

☐ PARENTAL AUTHORIZATION AND RELEASE FOR MINOR

By signing this form, I, have read and understand the above Authorization and Release and hereby give consent to CUUR and its employees and contractors to examine and test my child(ren), _____, and or myself. I understand that CUUR cannot guarantee any outcome or result and that my child(ren)'s results may be disclosed as required by law or contract. I understand that I may cancel this Authorization and Consent or limit the release of medical records for my child(ren) as provided in this Authorization and Consent. I have been informed about the Test's purpose, procedures, possible benefits and risks as provided in this Authorization and Consent, I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any time. I voluntarily agree to COVID-19 testing for my child(ren).

Printed Name of Parent or Legally Authorized Representative/Guardian:

_____

Signature of Parent or Legally Authorized Representative/Guardian:

_____