Consent for Use and Disclosure of Protected Health Information

I authorize the physician and/or healthcare staff of Capital Diagnostics to release any personally identifiable health care information (PHI), including but not limited to the diagnoses and records of any COVID 19 tests rendered to my child during the period of such care, to state and county healthcare departments, third party payers, and school nurses. I understand that this may be provided via electronic systems.

I hereby give my consent to Capital Diagnostics, CD, to use and disclose Protected Health Information about me and/or my child to carry out necessary treatment, payment, and healthcare operations. With this consent, Capital Diagnostics may mail documents to my home or other alternative location any time that assists the practice in carrying out treatment, payment, or healthcare operations. This could include patient forms and statements, so long as they are marked Personal and Confidential. In addition, Capital Diagnostics may e-mail me at the address provided any items that assist the practice in carrying out treatment, payment, or healthcare operations. While I have the right to request that the practice restrict how it uses and discloses my PHI, the practice is not required to agree to these requests. However, if it does so, it is bound by this agreement.

Name of student: _____

Name of Parent/Guardian: _____

Signature: _____Date: _____

COVID-19 Testing Consent

Authorizing Provider:	Testing Site:
Nasal Type of Test:	Lab Assigned:

Minor's Information

Minor's Name (Last, First Middle)	Minor's DOB (MM/DD/YYYY)
Preferred Parent/Guardian Phone Number	Minor's Address

I authorize that a test sample be taken for COVID-19 by Capital Diagnostics at Aidan Montessori School. By signing below, I authorize Capital Diagnostics to verify my insurance benefits and submit my claim to insurance or the HRSA Covid fund in case I do not have insurance for the 2021 calendar year. I understand I am responsible for patient responsibility indicated by my insurance carrier which is not otherwise covered by my carrier at Medicare rates. Ido hereby consent to testing my minor child and to use or disclose protected health information for reporting purposes.
I authorize my child's test results to be released to Aidan Montessori School.

SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILD UNDER 18

I, _____, have the following relationship with the person above:

Father Mother Stepfather Stepmother Court ordered legal guardian
Grandfather Grandmother Adult Aunt Adult Uncle Adult Brother Adult Sister

I have the legal authority, based on the relationship to the child as indicated above pursuant to s. 743.0645, F.S., to consent to this test administration for the child named above.

Parent or Guardian Signature	Date