PittCounty Public Health

Dr. John Silvernail, Director

GEN 141-E

MAKE:

MODEL:

COLOR:

General Consent For Services

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for Pitt County Health Department and have been informed that I may contact the person named therein if I have questions about the content of the notice.

I hereby voluntarily consent to medical examinations, treatments and procedures which are deemed necessary by the physician or other health care provider at the health department, including immunizations, TB skin test, HIV tests and other laboratory tests.

I have been informed that my medical information is confidential and is protected by NC law 130A-12.

I have been informed that if any problems are identified, recommendations will be made to me concerning appropriate follow-up and it is my responsibility to follow through with these recommendations. I will notify the Health Department of any changes in my address and/or telephone number so that I may be notified promptly if necessary.

My signature on this page indicates that I have been given the opportunity to have all my questions answered and have also been given the opportunity to refuse services. I understand that this consent is valid until I revoke it and that if I want to revoke this consent I must do so in writing.

I authorize the Health Department to submit claims to my insurance company on my behalf and in my name for any services rendered with the understanding that any benefit payments will be assigned directly to the Pitt County Health Department. I also authorize the release of any medical information needed to process any claim.

_____/_____ Client Signature Date

_____/_____ Witness Signature Date

_____/_____ Interpreter Signature Date

☐ I authorize Pitt County Health Department to contact me through electronic means, text messaging and/or voicemail, for appointment reminders at the telephone numbers I have previously provided.

☐ I authorize Pitt County Health Department to use my photograph to identify me and assist in my care. This information will not be released for any other purpose without my expressed written permission.

revised 10/30/18

PittCounty Public Health
John L. Silvernail, M.D., MPH
Health / Medical Director

Statement of Permission for COVID-19 Testing

Name: _____

Last **First** **Middle**

Gender: (circle) Male Female **Date of Birth:** _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

County of residence _____

Best contact phone number #: _____ ☐ Work ☐ Mobile ☐ home

Email address _____ **Preferred Language:** (circle) English Spanish Other

Ethnicity: (circle) African-American Caucasian Latino Other_____

Race: (circle) Black/ Non-Hispanic Hispanic Non-Hispanic White Asian/Pacific Islander

Native-American Other_____

Signed Patient Consent

By Signing Below: I hereby acknowledge that I have read and agree to follow the guidance *in NC DHHS Steps for People After COVDI-19 Testing*. _____ **(Please Initial)**

Notice of Privacy Practices

By Signing Below: I hereby acknowledge a copy of the "Notice of Privacy Practices" for the Pitt County Health Department was available for me to read and/or receive a copy. _____ **(Please Initial)**

Medical Record Release

By Signing Below: I authorize Pitt County Health Department to disclose COVID testing results to me, the patient, for personal use. I understand that I can access my results via MyChart. The Pitt County Health Department will contact me if the COVID-19 test result is positive. _____ **(Please Initial)**

Signature: _____ **Date:** _____

PittCounty Public Health
John L. Silvernail, M.D., MPH
Health / Medical Director

COVID-19 Questionnaire

What is your Primary Care Provider's name: _____	
Are you having COVID-19 symptoms?	(Chest pain, shortness of breath, cough, fever/chills, headache, no taste/smell, nausea/vomiting, diarrhea, fatigue/aches, sore throat) ☐ Yes ☐ No Date of symptom onset_____
Have you been hospitalized for COVID-19?	☐ Yes ☐ No Were you treated in an intensive care unit? ☐ Yes ☐ No
Is this your first COVID-19 test	☐ Yes ☐ No
Do you work in healthcare?	
Are you pregnant?	☐ Yes ☐ No
Do you live in	Nursing home? ☐ Yes ☐ No
	Group home? ☐ Yes ☐ No
	Board and care home? ☐ Yes ☐ No
	Homeless shelter? ☐ Yes ☐ No
	Foster Care? ☐ Yes ☐ No
	Residential setting for people with intellectual or developmental disabilities? ☐ Yes ☐ No
	Psychiatric treatment facility? ☐ Yes ☐ No

FOR HEALTH DEPARTMENT USE ONLY

87635 (COVID Test)	Date sample collected: _____ Specimen type: NP OP Nasal Specimen sent to: NCSLPH LabCorp Vidant Dx Code Z11.59 Specimen obtained by: _____ (print first name last name and discipline)