HIPAA AUTHORIZATION FORM

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Email: _____ **SSN Last 4:** _____

I authorize Rapid Reliable Testing, LLC ("RRT") along with their medical services provider, MD 1 Medical Care, PC. ("MD 1"), and laboratory partners (together with MD 1, the "Providers") to disclose my COVID-19 test results as between and among themselves with certain limitations listed below.

The **purpose** of this Authorization is to assist Company in determining my fitness for duty or ability to return to work in a Company location during the COVID-19 outbreak. The **specific information that may be disclosed** under this Authorization includes my name, contact information and any results of COVID-19 tests performed to Company or its affiliates.

I may refuse to sign or I may revoke this Authorization at any time and for any reason. If I decline to sign this Authorization, RRT and the Providers may continue to use and disclose my information for all purposes permitted by federal and state law.

My signed Authorization will **remain in effect** until I provide written notice that I revoke this Authorization or in one year, whichever comes earlier. I may revoke this Authorization by notifying the RRT Privacy Office by e-mail (compliance@rrtesting.com) or mail (Attention: Rapid Reliable Testing Privacy Officer, 35 West 35th Street, 5th FL, New York, NY 10001). The revocation will be effective immediately upon receipt of my written notice, except it will not have any effect on any prior action taken by Company in reliance on this Authorization. In particular, the revocation will not impact Company's, RRT's or a Provider's use or disclosure of health information already contained in my employee file, medical staff credentialing file or contractor file.

I understand that once my health information has been disclosed to the authorized recipient, the information potentially may be re-disclosed to others who, for the purposes of contact tracing, may not be required to abide by this Authorization or who are not subject to the same federal or state laws governing the use and disclosure of my health information.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions. By my signature, I authorize RRT and the Providers to use or disclose my health information in the manner described above.

_____ _____

Signature of Individual ***Date Signed***

_____

Printed Name

COVID-19 and IgG Antibody Testing Consent Form

I, _____, authorize a nasopharyngeal swab, nasal swab or saliva collection for COVID-19 Test and/or blood draw for IgG antibody test (collectively, "Specimen Collection") as required by my Employer. I further understand, agree, certify, and authorize the following:

1. I understand that my Employer has contracted with Rapid Reliable Testing, LLC ("RRT") for collection and testing of my specimen (nasopharyngeal, nasal swab, saliva collection and/or blood draw) (my "Specimen"). RRT has contracted with MD1 Medical Care, PC. ("MD1"), to perform the Specimen Collection, and BioReference Laboratories, Phosphorus, Boston Heart Diagnostics, PathMD, Ambry Genetics and Mako Medical Laboratories (collectively with MD1, the "Providers") for laboratory analysis and reporting regarding my Specimen.

2. I authorize RRT and MD1 to perform the Specimen Collection and BioReference Laboratories, Phosphorus, Boston Heart Diagnostics, PathMD, Ambry Genetics and Mako Medical Laboratories to test and report on my Specimen as further specified herein.

3. I authorize RRT and the Providers **to release the results of my test to my Employer.** I acknowledge and agree that my Employer may receive my test results before I do. I will be able to access my test results via secure email or a Patient Portal and I will receive Patient Portal access information.

4. I understand that I am not creating a patient relationship with RRT or the Providers by participating in testing. I understand none of RRT, the Providers or their personnel are acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regard to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I receive a positive test result, am feeling sick, or have any health-related questions or concerns.

5. I understand that Specimen processing and results reporting may vary.

6. I understand that Specimen Collection via nasal and/or nasopharyngeal may cause bleeding from the nose, I understand that the following conditions put me at a heightened risk for a nosebleed:

    a. Any history in the past year of nasal surgery.
    b. Any use of blood thinners, except Aspirin.
    c. Any nasal trauma within the last month.
    d. Any known bleeding disorders.
    e. Any intranasal use of cocaine or other illicit drugs.

7. Negative results do not rule out SARS-Cov-2 infection, particularly in those that have been in contact with the virus. Follow-up testing with a molecular diagnostic should be considered to rule out infection in these individuals. Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-Cov-2 infection or to inform infection status. Positive results may be due to past or present infection with non-SARS-Cov-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E. I understand that, as with any medical test, there is the potential for false positive or false negative test results. I agree that, by signing below, I am authorizing RRT to acknowledge the above on my behalf on the clinical laboratory's patient portal.

8. I recognize that there are certain inherent risks associated with Specimen Collection. I hereby consent for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily agree to have my Specimen Collection taken and analyzed by RRT and the Providers, and hereby waive any and all rights, claims, or causes of action of any kind whatsoever arising out of my participation in this activity, and do hereby release and forever discharge RRT and the Providers, and their employees, agents, representatives, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, economical or emotional loss, that I may suffer as a direct result of my participation in this activity.

9. I agree to indemnify and hold harmless RRT, the Providers, and their employees, agents, representatives, successors and assigns, against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including reasonable attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf.

I acknowledge that I have read, understand, agree, certify, and/or authorize the information above.

_____ _____

Signature Date