SOUTH DAKOTA STATE UNIVERSITY
RELEASE OF INFORMATION AND INFORMED CONSENT FOR COVID-19 TESTING

Name: **DOB:**

Student I.D. **Physical Address:**

City: **State:** **Zip:**

Email Address: **Phone #:**

Please carefully read and sign the following Release of Information and Informed Consent:

1 I voluntarily consent and authorize South Dakota State University (SDSU) to conduct specimen collection and laboratory testing and analysis, at the SDSU Student Health Clinic, the SDSU One Health Laboratory, or other laboratory for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action concerning my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider. This consent will be for multiple tests from date of signature through August 8, 2021.

2 Assignment of Payer Benefits – I agree SDSU Student Health Clinic and Counseling Services will bill and provide necessary health information to any payers. "Payers" are any health care insurance, private or government health plan/government agency (e.g. the South Dakota Bureau of Finance and Management, South Dakota Board of Regent); which pay health care costs or insurance policy that I have or another third party that will pay the charges I have incurred.

3 I authorize my test results to be disclosed to the South Dakota Department of Health (SDDOH) and the SDSU Point of Contact the Emergency Management Team Chair, the Vice President for Student Affairs, Residential Life Director, Director of Sports Medicine, and their designees, and other (please specify) .
This authorization to disclose will be effective for six months from the date of signature below. I understand that my test results may be subject to re-disclosure by these recipients and no longer protected.

4 The purpose of this disclosure is to assist with contact tracing and taking preventative measures to impede the spread of COVID-19.

5 I acknowledge that a positive test result is an indication that I must self-isolate in accordance with Center for Disease Control and Prevention and SDDOH guidance and per SDBOR Policy 1:26.

6 I understand SDSU and the SDDOH is not acting as my medical provider, this testing does not replace treatment by my medical provider, and 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 have questions or concerns, or if my condition worsen.

7 I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, I have been told that I can ask additional questions at any time, and I am aware of my rights to limit or revoke this authorization in writing as provided in the HIPAA Privacy Notice. I voluntarily agree to this testing for COVID-19.

Signature: **Date:**

This form must be signed by the individual being tested prior to specimen collection