Harris County Public Health
Building a Healthy Community

COVID-19 Testing Informed Consent – Minor

I consent for Harris County Public Health (HCPH) or any designated representative on their behalf to conduct collection and testing for SARS-CoV-2 (COVID-19) through a nasopharyngeal (NP) swab, under the authorization of the Local Health Authority (LHA) of Harris County, Texas.

- I authorize my child's test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
- I acknowledge that a positive test result is an indication that my child must self-isolate and/or wear a mask or face covering as directed by the LHA in an effort to prevent disease transmission.
- I understand that neither the testing unit nor the LHA is acting as my child's medical provider. This testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree to seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my child's condition worsens.
- I acknowledge the authority granted to the LHA under law and agree to follow any and all recommendations and/or orders direct to me under this authority.
- I understand that a "Not Detected" (negative) result does not rule out the possibility of COVID-19 and should not be used as the sole basis for treatment, patient management, or employment decisions. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

MEDICAL CONSENT AND AUTHORIZATION

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Patient/Guardian Initials

In the event of an emergency or non-emergency situation requiring medical treatment of the patient during the testing process, I/we, the undersigned parent(s)/guardian(s) of the patient, give Harris County Public Health my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the patient, including but not limited to administration of first-aid, use of an ambulance, and transfer to a hospital.

PRIVACY NOTICE

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Patient/Guardian Initials

I have been given a copy of HCPH Privacy Notice, which includes the HIPAA Privacy Rule.
I have had the opportunity to have the HCPH Privacy Notice explained to me.
I understand that HCPH will use and disclose my Protected Health Information for treatment, billing and healthcare operations without my written authorization. I understand my rights as described in the Notice.
I understand how to make a compliant if I feel my rights have been violated.

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that HCPH collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. For further information, contact Harris County Public Health – Health Information Services at 832-927-7647 or 832-927-7646.

REQUIRED FOR ALL PATIENTS

I attest that the information I have provided on this form is accurate and correct to the best of my knowledge. I hereby give my informed consent to the procedure/treatment/vaccination listed above. No warranty or guarantee has been made to me by the HCPH staff or contractors regarding the care or services that will be provided by HCPH. I certify that the services and care to be provided have been fully explained to me and my questions have been answered to my satisfaction.

_____ _____ _____
Full Signature of Patient/Parent or Legal Guardian | Date | Relationship to Patient

Address of signor: _____