

## GUSTAVUS POINT OF ENTRY



**Please Print  
Legibly**

**COMMUNITY TESTING DEMOGRAPHICS, RELEASE OF  
TESTING INFORMATION, AND WAIVER OF CLAIMS**

**TODAY'S DATE:** \_\_\_\_\_

Full Legal Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_  
First Middle Last

Home Mailing Address: \_\_\_\_\_  
Address City State Zip code

Phone #: \_\_\_\_\_ **E-mail Required:** \_\_\_\_\_

Community Testing Location	Race	Ethnicity
Check Testing Location: <input type="checkbox"/> Juneau <input type="checkbox"/> Sitka <input type="checkbox"/> Wrangell <input type="checkbox"/> Haines <input type="checkbox"/> Klawock <input checked="" type="checkbox"/> Other: <u>GUSTAVUS</u>  County: _____	<input type="checkbox"/> African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown by patient <input type="checkbox"/> Decline to answer	<input type="checkbox"/> Hispanic, White <input type="checkbox"/> Hispanic, Black <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other <input type="checkbox"/> Unknown by patient <input type="checkbox"/> Decline to answer

First Covid-19 Test	Employed in Healthcare	Do you have symptoms of COVID (As defined by CDC)	(Female) Pregnant?
<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES	<input type="checkbox"/> YES
<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO	<input type="checkbox"/> NO

**PURPOSE AND BACKGROUND.** The Southeast Alaska Regional Health Consortium ("SEARHC") is testing Patient to determine if Patient is currently infected with the COVID-19 virus, pursuant to the SEARHC community-wide COVID-19 testing program, which is voluntary. SEARHC is a tribal health organization that provides comprehensive health services throughout Southeast Alaska, under the Alaska Tribal Health Compact and Funding Agreements with the U.S. Secretary of Health and Human Services as authorized by Title V of the Indian Self-Determination and Education Act of 1975, as amended, 25 U.S.C. §§ 5301-5423.

**RELEASE OF RESULTS.** Patient understands that SEARHC is required by law to report positive test results directly to the State of Alaska for the purposes of COVID-19 infection prevention and response. Patient also understands that this information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and SEARHC will use or disclose the information only as permitted by HIPAA and described in its Notice of Privacy Practices. Patient understands that the information may no longer be protected by HIPAA once disclosed to the State of Alaska, and SEARHC has no control over the State of Alaska's use or disclosure of results.

**TESTING TYPE.** Patient will do a **NASAL SELF-SWAB PCR TEST**. Patient understands and agrees that SEARHC has the absolute discretion to choose the brand and type of test(s) used based on available supplies, patient and workforce demands, as well as any guidance currently in effect issued by the Food and Drug Administration or Centers for Disease Control and Prevention. SEARHC may interpret the test samples in-house or send the samples to outside labs for

interpretation. Patient may request details about the type of testing used by SEARHC. Patient understands that test results may not be made available immediately after the test is performed, and may take several days or longer to arrive, depending on the availability of test analysis facilities, equipment, and supplies.

**METHOD OF NOTIFICATION.** SEARHC will notify Patient of the test results by encrypted e-mail or the Patient may arrange to pick up the results by calling the number listed above. Patient acknowledges and understands that SEARHC does not control or have responsibility for the security of Patient's chosen e-mail account in order to prevent unauthorized access to Patient's e-mail.

**RISKS.** Patient understands that testing for the COVID-19 virus and interpretation of the test results is not perfect, and false positives or false negatives are possible. Patient further understands that nasal testing for COVID-19 may cause gagging, coughing, discomfort, or minor nosebleeds.

**WAIVER OF CLAIMS.** SEARHC is not responsible for the State of Alaska's actions or decisions regarding COVID-19 infection response and prevention, including any actions in response to a positive COVID-19 test result, including if the result is a false positive. Patient agrees and understands that it is patient's responsibility to protect others from infection pending and after receipt of the test results. SEARHC is not responsible for the consequences of a false negative result, such as the unintentional infection of other individuals, and any resultant illness, injury or death. Patient voluntarily and on behalf of Patient and Patient's heirs and assigns, hereby releases and forever discharges SEARHC, its officers, directors, trustees, board members, providers employees, agents, attorneys and assigns from all claims, demands, actions and causes of action whatsoever, of any sort, whether known or unknown, arising now, in the future, from or relating to in any manner whatsoever, SEARHC's testing of Patient pursuant to this consent to testing, including SEARHC's negligence and any injury, illness or death resulting from the testing or from SEARHC's negligence in administering the testing or directing Patient during the self-swab, or SEARHC's disclosure of the test results to the State of Alaska as otherwise required by law.

**BY SIGNING THIS AGREEMENT I AM REPRESENTING THAT I HAVE READ AND UNDERSTOOD THIS RELEASE OF TEST RESULTS AND WAIVER OF CLAIMS AND I AGREE TO BE BOUND BY ITS TERMS AND ASSUME ALL RISKS INHERENT IN OR ARISING FROM TESTING FOR COVID-19.**

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Patient (or Parent/Guardian on Minor's Behalf) Signature

DATED \_\_\_\_\_, 2020.