LABORATORY TEST REQUISITION FORM

870 VINE STREET LOS ANGELES CA 90038 1-800-799-7248 CLIA#: 05D22106322
LICENSE#: CLF348622 NPI#: 1609407725

IF THE INFORMATION BELOW IS INCOMPLETE OR INCORRECTLY FILLED OUT THERE MAY BE A DELAY IN THE PROCESSING OF SPECIMEN

PATIENT'S NAME (LAST) (FIRST)

DATE OF BIRTH SEX [] M [] F

ADDRESS

CITY STATE ZIP CODE

PHONE EMAIL

SPECIMENS RECEIVED:

FOR LAB USE ONLY

[] Oropharyngeal (Throat) Swab

COMMENTS _____

DATE RECEIVED:_____TIME RECEIVED: _____

[] M140 SARS CoV 2 (COVID-19) Molecular RT-PCR

CONSENT TO RECEIVE DIAGNOSTIC SCREENING FOR COVID-19 AND AUTHORIZATION FOR RELEASE OF DIAGNOSTIC INFORMATION

I wish to receive a diagnostic screening test for Covid-19 from Ultimate Dx Laboratories (UDX) which is provided to me by my employer at no-cost to me. I consent to UDX administering the test. I understand that the Americans with Disabilities Act, the Family and Medical Leave Act, the California Confidentiality of Medical Information Act, and other privacy laws prohibit my employer or contractor from disclosing my medical/health information. However, in the interest of the health of my co-workers and others with whom I may have had contact on my worksite, I consent to the following:

1) I consent to and authorize the release my Covid-19 test results from **UDX** laboratory to my HR department; AND
2) I consent to and authorize my Human Resources Department and/or to disclose to employees at my worksite and to others, i.e., clients, visitors, customers, whom I may have encountered at my worksite the following: a. if my test result is positive for the COVID-19 virus; or b. that I have been exposed to the virus by being in close contact with someone who is believed to be infected with the virus.

I acknowledge I have been advised that I am not required to agree to this consent and that there will be no adverse consequences to my employment or contract if I choose not to consent. Further, I acknowledge that my employer or contractor did not coerce or pressure me to agree to this consent and disclosure. In disclosing this information, I understand my contractor will take reasonable measures to keep my name and identity confidential to the extent possible. I recognize that circumstances may require identifying me by name as the infected or exposed individual in order to properly warn others so they may take precautionary measures and help prevent further spread of the virus. I also understand there are times when it is not possible to inform others they may have been exposed to the virus without them learning that it was through contact with me. This authorization expires on June 15, 2021, after which the contractor will no longer be authorized to disclose this information. I have been advised that I have a right to receive a copy of this authorization.

I AGREE TO THE ABOVE:

_____ _____ _____

NAME SIGNATURE DATE