Grupo/Organización: ______________________________ **Ciudad de Laubicación:** ______________

☐ empleado ☐ miembro del grupo ☐ familia ☐ volver a probar

Formulario de solicitud de prueba de paciente COVID-19

Complete este formulario y proporcione una copia de la tarjeta de seguro **del paciente** y el documento de **identidad** en el momento de **la recogida.**

Información del Paciente: Completado by Paciente o Guardián

Fecha de recogida de muestras:

Nombre de la Clinician (si corresponde):

Nombre:

Apellido:

Dirección:

Ciudad: | Estado: | Código postal: | Condado:

Correo electrónico (Imprimir claramente):

Número de teléfono:

Fecha de nacimiento: | Edad: | Sexo: ☐ no Binary ☐ macho ☐ femenino

¿Vive o trabaja el paciente en un entorno de congregación (por ejemplo, centro de atención a largo plazo, refugio, casa de grupo, prisión) ☐ **Sí** ☐ **No**

Información clínica del paciente

Fecha de inicio de los síntomas:

Síntomas observados: ☐ Ninguno

fiebre ☐
☐ Cansancio
☐ tos seca
☐ dolor corporal
☐ la congestión nasal
☐ nariz con nequeo
☐ pérdida del olfato
☐ diarrea
☐ Pérdida de apetito

¿El paciente tiene alguna condición subyacente?

☐ Ninguno
☐ Embarazada
☐ Diabetes
☐ Hipertensión
☐ Enfermedad cardíaca
☐ otros
☐ Inmunocomprometidos
☐ Desconocida
☐ Enfermedad Pulmonar Crónica
☐ enfermedad hepática crónica
☐ enfermedad renal crónica

PRUEBAS DE LABORATORIO – Completado por el Paciente

¿Ha recibido el paciente la vacuna contra la gripe? ☐ **Sí** ☐ **No**

¿Ha recibido el paciente la vacuna COVID-19? ☐ **Sí** ☐ **No**

PRUEBAS COVID 19 – Completado por el paciente

¿Se ha realizado la prueba del paciente para COVID-19? ☐ **Sí** ☐ **No**

Resultado: ☐ **positivo** ☐ **negativo**

Por la presente reconozco y doy el consentimiento completo y completo para las pruebas y la solicitud:

☐ **prueba de hisopo COVID RT-PCR** ☐ **prueba SARS-Cov2 IgG Anticuerpo** ☐ **prueba sars-cov2 Igm Anticuerpo**

FUENTE de prueba de hisopo RT-PCR: ☐ **hisopo anterior nares (fosanasal)** ☐ **hisopo nasofaríngeo (nasal)** ☐ **hisopo orofaríngeo (garganta)**

Por la presente reconozco el consentimiento total y completo y hago la solicitud de un SARS-Cov2 qPCR y/o IgG. Soy físicamente capaz de tener este hisopo nasal / extracción de sangre y nunca he tenido una reacción adversa a cualquier servicio de flebotomía. Por la presente solicito y autorizo a PMH Laboratory, Inc. a un subcontratista designado que es una enfermera independiente / agencia de personal de atención médica, no afiliada directamente con PMH Laboratory, Inc., para recoger esta muestra para mí o la persona nombrada anteriormente para quien soy el tutor legal. Por la presente libero PMH Laboratory, Inc. sus directores, directores, miembros, empleados, afiliados, proveedores, proveedores, subcontratistas, sucesores, agentes, sus respectivas compañías de seguros y la ubicación que patrocina esta clínica/programa, sus directores, directores, empleados, afiliados, sucesores o agentes de cualquier responsabilidad, lesión o daño que surja de, o de alguna manera relacionado con, este SARS-CoV-2 qPCR y/o IgG Anticuerpo Test o la administración de la misma incluyendo, pero no limitado a, actos de negligencia. Autorizo que mi información médica en este documento, incluidos los resultados de las pruebas, se comparta con mi médico/seguro/empleador/escuela/organización o grupo. PMH Laboratory, Inc., utilizará y divulgará su información personal y de salud para tratarlo, para recibir el pago de la atención que brindamos, a las agencias de salud pública según sea necesario y para nuestras otras operaciones de atención médica que generalmente incluyen esas actividades que realizamos para mejorar la atención de calidad. Hemos preparado un AVISO detallado DE PRIVACIDAD Y PRÁCTICAS DE CONFIDENCIALIDAD para ayudarle a entender mejor nuestras políticas con respecto a su información personal de salud. Reconozco que he recibido una copia del Aviso de Prácticas de Privacidad y Confidencialidad. Acepto permanecer en el área general durante al menos 5 minutos después de la recolección de muestras. Proporcione una copia de este formulario a su médico y/o proveedor de atención médica para sus registros médicos. Esta prueba es solo para fines informativos y para ser discutida con su profesional de la salud. PMH Laboratory, Inc., no le proporciona asesoramiento médico ni son responsables de ningún resultado en su atención o tratamiento. Tenga en cuenta que un resultado positivo no significa que sea inmune o no pueda volver a infectarse. Esta prueba fue desarrollada, y sus características de rendimiento determinadas por PMH Laboratory, Inc. Esta prueba no ha sido aprobada ni aprobada por la FDA. Esta prueba ha sido autorizada por la FDA bajo una Autorización de Uso de Emergencia (EUA). Esta prueba ha sido validada de acuerdo con el Documento de Orientación de la FDA (Política para pruebas diagnósticas en laboratorios certificados para realizar pruebas de alta complejidad bajo CLIA antes de la Autorización de Uso de Emergencia para la Enfermedad coronavirus-2019 durante la Emergencia de Salud Pública) publicado el 20 de abril de 2020. La revisión independiente de la FDA de esta validación está pendiente. Esta prueba sólo está autorizada durante el tiempo que dure la declaración de que existen circunstancias que justifiquen la autorización del uso urgente de pruebas diagnósticas in vitro para la detección del virus SARS-CoV-2 y/o el diagnóstico de la infección por COVID-19 en virtud del artículo 564(b)(1) de la Ley, 21 U.S.C. 360bbb-3(b)(1), a menos que la autorización se rescinda o revoque antes.

Firma del paciente/guardián: ______________________________ **FECHA:** ______________

5862 Edinger Ave ◊ Huntington Beach ◊ CA ◊ 92649 ◊ (562) 592-2890 oficina ◊ (00 909) 803-9790 Fax CLIA 05D2137011 ◊ ESTADO CLF351210 ◊ COLA 028736
Rahil R. Khan, MD – Director de Laboratorio

FORMULARIO DE CONSENTIMIENTO DE PADRES / TUTORES PARA PRUEBAS DE COVID DE ESTUDIANTES

Por la presente brindo consentimiento total y completo y hago una solicitud para las pruebas de Covid para mi hijo/a mientras sea estuduante de hasta junio 2022. Por la presente solicito y autorizo al subontratista designado de PMH Laboratory, Inc. Que es un/a enfermero/a de atencion medica independiente – agencia personal, no afiliada directamento con PMH Laboratory, Inc., para recolectar esta muestra de la persona nombrada a continuacion de quien soy el/la tutor/a legal. Por la presente libero a y The PMH Laboratory, Inc. de toda responsabilidad. Entiendo que esta prueba es voluntaria y que tengo la opcion de harcer pruebas semanales para mi hijo/a por mi cuenta. Tambien entiendo que los resultados de las prueba de Covid solo se compartiran con el personal administrativo/ personal de apoyo necesario de y solo se utilizaran para los fines de la asitencia de mi hijo/a a .

PMH Laboratory, Inc., no le brinda asesoramiento medico ni es responsable de los resultados de las pruebas.

NOMBRE DEL NIÑO/NIÑA (Por favor use letra de molde): ______________________________

FIRMA DEL PADRE/MADRE/TUTOR: ______________________________

FECHA: ______________________________

5862 Edinger Ave. Huntington Beach, CA 92649 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com
18249 Gothard St. Unit 101, Huntington Beach, CA 92648 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com

Fecha: ____________

HRSA COVID-19 Programa Sin Seguro

Nombre: ______________________ Inicial: __________ Apellido: ____________________________

Fecha de Nacimiento:______Genero:__________ Numero de Seguro Social: _________________

Estado de Residencia: ______ Licencia de Conducir #: _____________ Fecha del Servicio: ________

Laboratorio PMH, Inc. declara que ha intentado obtener la información mencionada en la parte superior previo a someter la aplicacion.

Yo certificó que el paciente no tiene aseguranza, Federal, Privada, or covertura Medicare. El status del paciente es no asegurado.

Firma del Paciente: ______________________________

* Agregar una copia de le Licencia de Conducir y Tarjeta Dėl Seguro Social

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

PMH Laboratory, Inc, its affiliates, subsidiaries and/or divisions (collectively referred to as "PMH Laboratory") is required by law to provide you with this notice explaining PMH Laboratory's privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment and health care operations, as well as for other purposes that are permitted or required by law. PMH Laboratory is required by law to follow the procedures described in this Notice of Privacy Practices as long as the Notice remains in effect. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

PMH Laboratory is required to protect the confidentiality of your protected health information and to inform you if your protected health information has been acquired, accessed, used, or disclosed by unauthorized persons.

WHAT IS PROTECTED HEALTH INFORMATION?

Protected Health Information (PHI) includes both medical information regarding your care and treatment and individually identifiable personal information such as your name, address, phone number, social security number or other personal information that you provide in the course of your treatment. This information may be in electronic, written and/or oral form.

HOW PMH LABORATORY MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
PMH Laboratory may use and disclose PHI about you, without your authorization, for the purposes described below.

Treatment: PMH Laboratory may use and disclose your health information to provide, coordinate or manage your healthcare by us and other healthcare providers. This includes, but is not limited to, disclosures about you to doctors, nurses, technicians, staff, and other healthcare professionals who become involved in your care.

Payment: PMH Laboratory may use and disclose your health information to receive payment for services provided to you, or to obtain prior authorizations for proposed treatments.

Healthcare Operations: PMH Laboratory may use your health information for our own operations. We may also use and disclose your health information to health professionals for educational purposes. These uses are required to run our company and to make sure that all our patients receive quality care.

Treatment Issues: We may call you with test results or to answer your questions about your care or use and disclose health information to inform you about treatment options and alternatives.

Health-Related Benefits and Services: We may use and disclose personal and health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved In Your Care or Payment For Your Care: Unless you object, we may disclose your health information to a relative, friend or any person identified by you, if these individuals need to know about or are involved in your care, or for payment for your care.

Workers Compensation: PMH Laboratory may disclose your health information to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

Public Health, Safety, Disaster Relief, Or to Divert a Threat to Health Or Safety; Victims of Abuse, Neglect, or Domestic Violence: PMH Laboratory may use or disclose your health information to the extent necessary for public health activities and to avert a serious and imminent threat to your health or safety or the health and safety of others. PMH Laboratory may disclose your personal and health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes. Any disclosure would only be to someone able to help prevent the threat or injury.

Health Oversight: PMH Laboratory may disclose your health information to a health oversight agency for activities authorized by law. This may include but is not limited to The Joint Commission, ACHC, surveys, investigations, inspections, licensure, or disciplinary actions.

Legal Proceedings and Law Enforcement: PMH Laboratory may disclose your health information if asked to do so by a law enforcement officer and/or in response to a subpoena, court or administrative order, warrant, discovery request or other lawful process.

Military and National Security: PMH Laboratory may disclose your health information to authorized military command authorities or federal officials if you are in the armed forces or are a veteran, or as required for lawful intelligence, counter intelligence and other national security activities.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner or medical examiner if necessary to identify a deceased person or to determine a cause of death, or to a funeral director in connection with the performance of their duties.

Business Associates: PMH Laboratory may provide some services through contracts with business associates. In those instances, PMH Laboratory requires the business associates to safeguard your information through a Business Associate Agreement.

Research; Death; Organ Donation: PMH Laboratory may use and disclose your health information for research purposes in limited circumstances. However, all such research projects are subject to an approval process, and we will ask your permission if a researcher is to have access to your name, address, or other information that identifies you. PMH Laboratory may disclose your health information for the purpose of facilitating organ donation and transplantation.

Required by Law: PMH Laboratory will use or disclose your health information when required to do so by federal, state, or local law.

USES OR DISCLOSURES NOT COVERED BY THIS NOTICE.
Uses or disclosures of your health information not covered by this notice or the laws that apply to PMH Laboratory may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

YOUR RIGHTS REGARDING YOUR PERSONAL AND MEDICAL INFORMATION.
Although your medical record is the property of PMH Laboratory, the information belongs to you. Federal law gives you the rights described below regarding your medical information.

<u>Inspect and Copy.</u> With some exceptions, you may review and copy your medical information. To the extent your record is maintained electronically, you have the right to access your own electronic health record in an electronic format. You may also direct PMH Laboratory to send the e-health record directly to a third party.

<u>Amendments.</u> You may ask us to amend your medical information if you feel it is incorrect or incomplete. However, we may deny your request under certain circumstances.

<u>Accounting of Disclosures.</u> You may request a list of certain disclosures made of your medical information ("accounting of disclosures"). In some instances, the accounting may be limited by time and may exclude disclosures made for treatment, payment, or health care operations.

<u>Right to Request a Restrictions.</u> The HIPPA Privacy Rule provides that you may request a restriction on the protected health and medical information the Plan uses or discloses about you for payment or health care operations. If you pay for your services, in full, using your personal funds, you can ask that the information regarding the service not be disclosed to a third-party payer since no claim is being made against the third-party payer. This request must be made in writing and we are not required to agree with your request.

<u>Right to Request Confidential Communications.</u> If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Plan communicate with you in an alternative manner or at an alternative location. You may request that we communicate with you about medical matters in a confidential manner or at a specific location. This request must be made in writing.

<u>Paper Copy of This Notice.</u> You may request a paper copy of this notice at any time by contacting your local PMH Laboratory office or PMH Laboratory's Privacy Officer. You may obtain an electronic copy of this notice at our website: www.wellnessgrp.com.

To exercise any of these rights you must: submit your request in writing to your local Wellness Group office or PMH Laboratory's Privacy Officer. Your request should include a reason for your request and, if applicable, the action you want PMH Laboratory to take. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to change or take back your request at that time before any costs are incurred.

BREACH NOTIFICATION REQUIREMENTS: PMH Laboratory is required to notify you if unsecured PHI is acquired, accessed, used and/or disclosed by an unauthorized party. Notification must occur without unreasonable delay and no later than 60 days of the event.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each PMH Laboratory office and on its website (www.wellnessgrp.com). In addition, if material changes are made to this notice, the notice will contain an effective date for the revisions and copies can be obtained by contacting your local PMH Laboratory office or PMH Laboratory's Privacy Officer.

EFFECTIVE DATE: This Notice of Privacy Practices is effective January 1, 2020.

QUESTIONS/GRIEVANCES: If you want further information about matters covered by this notice, are concerned that your privacy rights may have been violated, or disagree with a decision made about access to your personal and health information, you may contact PMH Laboratory's Privacy Officer by U.S. mail, fax, phone or email at: **PMH Laboratory, Attention: Privacy Officer, 5862 Edinger Ave Huntington Beach, CA 92649; (562) 592-2890 Fax: (909) 803-9790; e-mail: info@pmhlaboratory.com.** You may also submit a grievance/complaint to the U.S. Department of Health & Human Services, 200 Independence Ave., SW, Washington DC 20201, Phone: 202.619.0257, Toll Free: 1.877.696.6775.

PMH Laboratory will not retaliate and you will not be penalized in any way if you choose to file a grievance complaint with us or with the U.S. Department of Health and Human Services.