|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last Name:** |  | **First Name:** |  | |
| **Date of Birth:** |  | **Phone Number:** | |  |
| **Email:** |  | | | |
| **Reason for Test:** |  | | | |

1. Are you experiencing any of the following symptoms? Check all that apply:

* Fever (at or greater than 100 degrees Fahrenheit)
* Chills
* Cough
* Shortness of breath or difficulty breathing
* Fatigue
* Muscle or body aches
* Headache
* New loss of taste or smell
* Sore throat
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea

1. In the past two weeks, did you care for or been deemed a close contact of someone diagnosed with COVID-19?

□ Yes □ No

1. Have you or anyone in your household traveled in the U.S. in the past 21 days?

□ Yes □ No

1. Have you or anyone in your household traveled on a cruise ship in the last 21 days?

□ Yes □ No

1. Are you or anyone in your household a health care provider or emergency responder?

□ Yes □ No

1. How would you like to be notified of your results?

* Email
* Phone

1. Do you need an official copy of your results?

□ Yes □ No

If yes how would you like to receive your copy?

* Email
* Pick up in pharmacy
* Mail to this address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I hereby consent and state my preference to have **(insert pharmacy name here)** and its staff to receive my test results from the North Dakota state lab and communicate with me my COVID-19 test results and any additional relevant medical information. The email address or telephone number at which I would like to receive my results is provided above.

I understand that email is not a confidential method of communication and may be insecure. I further understand that, there is a risk that my results may be intercepted and/or read by a third party.

I understand that this authorization remains in effect for five years from the date hereof unless specifically revoked by written notice.

I agree to pay the **(insert price here)** fee that will be assessed for my appointment. I understand that this fee does not cover the test itself which is provided for free by the State of North Dakota but is assessed in consideration of time, costs and risks undertaken by the pharmacy offering this service.

Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_