PRIMECARE MEDICAL
OF NEW YORK, INC.
The Choice for Quality Correctional Health Care

COVID-19 TESTING CONSENT FORM

I give permission for PrimeCare Medical of New York, Inc. and Personalcare Registered Professional Nursing, PC staff (collectively, "PrimeCare") to perform a COVID-19 test on me. The testing process has been explained to me and I have had an opportunity to ask any questions I may have. I acknowledge that PrimeCare cannot guarantee the accuracy of the result and that it may be necessary for me to undergo additional testing in the future. I recognize that even if I have a negative result now, I can still contract COVID-19 in the future. Administering the test does not create a patient/physician relationship between me and PrimeCare or any of its employees, nor does it obligate PrimeCare or its staff to perform any other care or treatment for me. I authorize PrimeCare to receive my test results and convey them to me. I understand by undergoing the test PrimeCare may have to report the results to the Department of Health or other agencies.

Name Printed: _____

Signature: _____

Date: _____

Facility: _____