**Employer: Milan Eye Center**

**Consent Form**

 **Covid-19 Patient Testing**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to a (1) nasopharyngeal or oropharyngeal swab for COVID-19 Testing and (2) that my results can be released to my Employer.

I affirm that I am the above named employee and understand the above conditions. I authorize Peachtree Immediate Care to conduct COVID-19 Testing. I release Peachtree Immediate Care from any liabilities, claims, and causes of action (known or unknown, contingent or fixed) that may result from these tests.

Print Employee Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee/Resident Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_