PATIENT NAME _____ PATIENT DOB _____

GENDER _____ HISPANIC Y/N _____ RACE _____ PHONE # _____

ADDRESS _____ CITY _____ STATE __ ZIP _____

COUNTY: _____

Public Health
Prevent. Promote. Protect.
Woodford County Health Department

Are you a healthcare worker? Yes / No

Are you associated with a school? Yes / No

Are you a resident of a congregate setting? Yes / No

Are you symptomatic? Yes / No

If yes, what symptoms? _____

What date did symptoms start? _____

Are you pregnant? Yes / No

There will be no cost to you for the COVID-19 Test

SPECIAL NEEDS

Woodford County Health Department tries to meet your special needs. Please help us by circling or noting items you would like assistance with:

Sign Language/ Interpreter Translator Language Other: _____

_____ **NOTICE OF PRIVACY PRACTICES:** I understand I have a right to review Woodford County Health Department's Notice of Privacy Practices prior to signing this document. Woodford County Health Department's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Woodford County Health Department. This Notice of Privacy Practices also describes my rights and Woodford County Health Department's duties with respect to my protected health information.

_____ **HIPAA:** A copy of the Woodford County Health Department Privacy Practices has been offered to the patient and are available upon request.

_____ **Consent to text or email results:** The Woodford County Health Department utilizes National and State databased required to report results. I consent to texting and/or emailing test results directly to the phone number or email provided.

_____ **PERMISSION AND RELEASE OF INFORMATION:** I understand that by signing this document I am giving permission to the Woodford County Health Department to:

1. Complete the necessary examinations, immunizations, laboratory tests, and screenings appropriate for my child/my personal visit.
2. Contact me regarding clinical visits and appointments by telephone, postage mail or social media.
3. Release information to my personal/child/family physician(s), WIC program management, Healthy Start programming, other Cornerstone Programs, state/local health departments, and appropriate reporting database.

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

_____ _____

Printed Name of Patient (or Parent/Legal Guardian) Relationship to Patient