

Registration for COVID-19 Surveillance Testing

The information provided below will be used to identify your record which will be stored in the University of Denver Health & Counseling Center HIPAA-compliant database and reported to the state with test results as required by law.

	Last Name		Date of Birth
	1	Mobile Phone	
Male	Female	Othor	
	Tomale		
	State		Zip Code
	Male	Male Female	Mobile Phone Male Female Other

- I authorize the COVID-19 testing unit to conduct collection and testing of COVID-19 through a salivary sample.
- I understand that my personal information and sample are to be analyzed by a lab on campus and my
 results will be disclosed to the University, county, state or any other government entity as required by
 law.
- I understand this consent is for testing only and the testing unit is not acting as my medical provider.
 This test does not replace treatment by my medical provider, and I assume complete and full
 responsibility to take appropriate action with regards to my test results. Although the testing unit is
 not my medical provider, I understand that the testing unit follows the Health and Counseling Centers
 Notice of Privacy Practices for confidentiality of health records and is available here.
- I acknowledge that a positive test results is an indication that I must self-isolate as directed in the effort to avoid infecting others.
- I agree to seek medical advice, care and treatment from my medical provider if I have questions or concerns.
- I understand that as with any medical test, there is the potential for false positive or a false negative. By signing this registration process for COVID-19 testing I acknowledge that I have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign and I have been told I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Signature	Date	