<table>
<thead>
<tr>
<th>SARS-CoV-2 (COVID-19) Qualitative PCR</th>
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<tbody>
<tr>
<td>Specimen Type:</td>
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<tr>
<td>✓ NP</td>
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ICD-10 Codes:
- ☐ Z20.828 COVID-19 Screening
- ☐ Other: ____________________________
EWU COVID-19 Testing Informed Consent and Authorization

Please read carefully and sign the following informed consent and authorization:

1. I authorize Incyte Diagnostics to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider.

2. I authorize Incyte Diagnostics to disclose my test results to Eastern Washington University for public health purposes, to include contact tracing, or any other governmental entity as may be required by law.

3. I acknowledge that a positive test is an indication that I must self-isolate in accordance with all EWU current COVID-19 protocols and the instructions of EWU Health and Wellness staff, EWU Human Resources and/or the Spokane Regional Health District (SRHD).

4. I understand that Incyte Diagnostics is not acting as my medical provider and this test does not replace or substitute treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and I agree I will seek medical advice, care, and treatment from my medical provider if I have questions, concerns, or my condition worsens.

5. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I understand and 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 that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

____________________________   __________________________
Signature      Date

____________________________
Printed Name