COUNTY OF SANTA CLARA
Health System

Asymptomatic Healthcare Worker COVID-19 Testing

Healthcare Worker Information **Please Write Clearly and Complete Both Sides.**
Complete only once. Form is valid through December 31, 2021 unless revoked.

Last Name: _____ First Name: _____

Date of Birth: (month/day/year): _____ / _____ / _____
Month / Day / Year

Employee ID:_____
(Mandatory for County employees)

Work Unit: _____

Sex on CA ID or DL: Male Female Nonbinary Prefer Not to State

Phone Number: ( ) -

☐ I am participating in the Healthcare Worker COVID-19 screening program ("Program"). I consent to be tested each time I present for COVID-19 testing pursuant to this Program for the duration of the Program. I understand that I will be tested for COVID-19 multiple times.

☐ I agree that I will not seek testing through the Program if I have COVID-19 symptoms or if I have had a previously positive COVID-19 test result within the last 90 days.

This consent form will be valid through December 31, 2021 unless I revoke my consent in writing and submit to Employee Health Department.

Signature: _____

Print Name: _____ Date: _____

For Employee Health Staff Use Only:

☐ NASAL

Place Nasal Label Here

DATE COMPLETED: _____
TIME COMPLETED: _____
NAME: _____

COUNTY OF SANTA CLARA
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[Patient Sticker/Demographics]

CONSENT TO COVID TESTING

The County of Santa Clara ("County") is providing asymptomatic COVID-19 testing to its healthcare workers on a routine basis. There is no cost to you for testing, however, if you have health insurance that covers this service, your permission is necessary to bill your insurance through HealthLink.

I authorize my COVID-19 testing to be completed in HealthLink, which allows the County to bill my insurance for the testing service each time I am tested in the County's COVID-19 testing program.

CONTACT WITH TESTING RESULTS

Positive results will be provided to me via a phone call.

All results will be available for my review in the Employee Health ReadySet system and via an active myHealthOnline account.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS

I assign and transfer to the County any right to reimbursement or compensation in connection with any insurance plan, health benefit plan, or other source of payment for COVID-19 testing provided to me by the County. This assignment shall include assigning and authorizing direct payment to the County of all insurance and health plan benefits payable for this outpatient service.

If I am employed by the County, the County shall indemnify me against any claims by my insurance plan, health benefit plan, or other source of payment for the asymptomatic COVID-19 testing referenced above, including any claims for co-payments and similar charges.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the ***Notice of Privacy Practices (NPP)*** of the County of Santa Clara Health System (CSCHS). The NPP provides information about how my medical or protected health information (PHI) may be used or disclosed. The NPP is subject to change. If it is changed, the CSCHS will post the revised version in its facilities and on its website here: https://www.scvmc.org/patients-and-visitors/services/Documents/Notice%20of%20Privacy%20Practices%20-%20English%20Mar%202019%20final.pdf

I certify that I am the patient and authorized to sign and accept these terms on my behalf.

Signature: _____

Print Name: _____ **Date:** _____