Manisha Juthani, MD
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

ATTESTATION OF INSURANCE COVERAGE

To be completed by the patient when COVID-19 testing is ordered:

Date of Service: _____

Patient Name: _____

Date of Birth: _____

Required Information (must complete one of the options):

****

MEDICAL BENEFITS:

Co-Pay – will be paid by State of Connecticut

Insurance Carrier: _____ **Patient ID:** _____

Group: _____

****

NO INSURANCE COVERAGE:

You Will Not Be Denied Testing

I do not have health care insurance such as individual, employer-sponsored, Medicare or Medicaid coverage. Therefore, I affirm and attest the above named patient has no health care insurance. If this statement is false, I understand that I may be subject to the penalties of false statements pursuant to Conn, Gen, Stat, §53a-157b.

_____ _____ _____

Signature of Patient/Legal Guardian **Date** **Relationship to Patient**

Address: 25 Science Park, 3rd Fl, 150 Munson St. New Haven, CT 06511-3572

Physician or Account Name: Yale University

Phone: _____

Email: marisa.zurlo@yale.edu stephanie.weirsman@yale.edu

Client Account #: _____

Connecticut Department of Public Health

Phone: (860) 509-7101 • Fax: (860) 509-7111
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer

ATTACHMENT 3

STATE OF CONNECTICUT
DEPARTMENT OF
Public Health

PLEASE INDICATE YOUR TESTING PURPOSE:

◯ **SYMPTOMATIC**

◯ **EXPOSED**

◯ **TRAVEL**

◯ **WEEKLY TESTING DUE TO STATE MANDATE**

- ◯ **LONG-TERM CARE**
- ◯ **EDUCATION / CHILDCARE**
- ◯ **STATE EMPLOYEE**

◯ **TESTING DUE TO OTHER EMPLOYER MANDATE, NOT ASSOCIATED WITH STATE MANDATE**

◯ **OTHER** _____

Consent to SARS-CoV-2 Testing

This form explains the SARS-CoV-2 test provided by Yale University's School of Medicine, Department of Pathology ("Yale" or "Yale Department of Pathology"). You should review this form and sign the acknowledgment below. If the test will be received by a minor child, the child's legal representative must review this form and sign on behalf of the minor child.

The test that you will receive is designed to detect if you have SARS-CoV-2, also known as the "coronavirus." SARS-CoV-2 is the virus that causes the disease known as COVID-19. The results of this test will **not** tell you if you had the virus in the past or if you have immunity to getting the virus in the future. **It only tests for the presence of the virus in your specimen at the time of the test.**

Your specimen will be collected through a process that involves providing a saliva sample. Your results will be made available to you and may also be shared with the Connecticut Department of Public Health and certain federal, state, or local government agencies as required by law.

The Yale Department of Pathology will not be sending a copy of your results to your doctor. If your results are positive (i.e., they indicate the presence of the virus), please contact a doctor immediately. Only a doctor can diagnose you with COVID-19 and give you information about what you should do next. As further outlined in the Fact Sheet for Patients, negative results mean that the virus was not detected in your specimen. It is possible for the test to produce an incorrect negative result (called a "false negative") in some people who have SARS-CoV-2. If you test negative but have symptoms of COVID-19 or concerns about exposure to SARS-CoV-2, contact a doctor to determine if you should be retested or take other action.

You should talk to a doctor about any health care needs you may have, including any related to receiving this test. Yale's Department of Pathology is not acting as your medical provider and is not responsible for any medical care you receive.

If there is leftover specimen after your test is performed, Yale may remove information that identifies you from the specimen and use it for quality assurance, validation and laboratory testing development.

By signing below you agree: (i) that you have read and understand the information in this consent form and related documents such as the Fact Sheet for Patients and have had the opportunity to ask questions; (ii) to provide a saliva specimen for testing; (iii) to have your specimen tested by Yale for SARS-CoV-2; and (iv) that your leftover specimen and/or information about you may be used without information that identifies you after the testing is over for analysis. You voluntarily agree to this testing for SARS-CoV-2.

Name of Patient: _____

_____ _____

Signature of Patient or Legal Representative Date

Name of Legal Representative (if applicable): _____

Relationship to Patient (if applicable): _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the Yale School of Medicine Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name (Print) Relationship to Patient