**Patient Consent Form for COVID Testing**

**Test Consent.**

I hereby give consent to Sema4 to perform testing related to SARS-CoV-2 and COVID-19 ("COVID-19 Test"). I have received adequate information regarding this testing, and I understand that specimen(s), such as a peripheral blood, nasopharyngeal (nose), oropharyngeal (throat), and/or saliva, will be collected from me in connection with this testing. I understand that a result of "not detected" reduces, but does not eliminate, the possibility that I carry SARS-CoV-2, and (where applicable) that a result of "detected" for antibodies to SARS-CoV-2 does not guarantee that I am immune to COVID-19. I understand that no test will be performed on my sample(s) other than the one(s) authorized by me.

I understand that this consent is being obtained in order to ensure that I understand the test(s) that will be performed on my sample(s). I understand that the results of this testing may become part of my medical record and may only be disclosed to individuals who have legal access to this record or who I designate to receive this information.

**Financial Consent.**

**Authorization of Payment of Insurance Benefits.** I authorize payment to Sema4 of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of the COVID-19 Test. I hereby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

**Signature on File (For Medicare patients).** I certify that the information given to me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to Sema4 for services provided by Sema4.

**Authorization for Release of Information.** I authorize Sema4 to release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for the COVID-19 Test; (3) to any person or entity which is, or may be liable to Sema4 for all or part of Sema4's charges, including but not limited to, third party payors; (4) to any governments agency or other organization responsible for oversight of Sema4 or a third party payor; (5) for Sema4's normal health care operations. I authorize Sema4 to communicate with me by telephone or through text or email, even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet.

By signing below, I agree to the Test Consent and Financial Consent.

Signed: _____

NAME: _____

DATE: _____