Pediatrics East Of New York, P.C
Covid19 Testing Registration

1015 Madison Ave Ste 502
New York, NY 10075

Patients Full Name_____ (DOB) _____

Address: _____APT._____

City/State/Zip_____

Primary phone# (_____) _____ Email address: _____

EMPLOYER/ SCHOOL NAME: _____

PLEASE **CIRCLE** THE ANSWER THAT APPLIES TO YOU

Was the patient in school or work in the past 7 days? **Yes** **No** Pregnant or Postpartum **Yes** **No**

Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea?

If yes, Symptoms Onset Date _____

Our staff will not be discussing treatment options or providing any recommendations to the patient. All patient questions should be addressed to your health care provider or NYC DOH.

My signature at the bottom of this form is authorization for Pediatrics East Of New York, P.C. to disclose the health information of the above-named patient via the email address provided above. It also confirms my understanding that: I agree to seek medical care and all recommendations from my health care provider. I understand that the provided information is protect by HIPAA, but I acknowledge that these results will be forwarded to NYS Department of Health. I certify that the information provided above is correct. I understand that I am financially responsible for fees incurred for testing. I hereby authorize physicians at Pediatrics East of New York, P.C. to release all information necessary to secure payment.

- Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Law may no longer protect re-disclosure.
- Once transmitted, I am responsible for safeguarding the information I receive
- I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a Revocation of Release of Medical Information Form. A revocation will not apply to information that has already been released because of this authorization.
- I am responsible for notifying the Pediatrics East Of New York, P.C party listed below if my e-mail address changes and completing another authorization to communicate using a different address
- If I am communicating via e-mail about someone else, I attest that I am responsible for that person's care or payment and will indicate my relationship to the patient below
- Pediatrics East Of New York. P.C will not condition treatment or payment upon receipt of an authorization.

_____ _____

Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____

Name of Person completing form Relationship to patient (if not patient)