



Swallow School District Informed Consent

I give the Swallow School District consent to access my/my child's Covid-19 PCR test result(s) performed by Summit Clinical Laboratories in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Student/Employee name

Student/Employee DOB (mm/dd/yyyy)

Parent/legal guardian name (Print)

Signature

Date (mm/dd/yyyy)