CI Medical Center

(Center for Integrated Medicine)
8278-A Bellaire Blvd.; Houston, TX 77036
TEL: 713.272.8858

Please fill out the form below & call our office for an appointment for testing.

Waiver for Medical Doctor Evaluation prior to COVID-19 Testing

PATIENT INFORMATION						
Name ____ (First Name) (Last Name) (Middle Initial)			Date of Birth ____ (mm/dd/yyyy)		Age ____	
Address ____		City ____	State ____		Zip Code ____	
Phone Home ____		Work ____			Cellular ____	
Email ____						
Driver's License No ____				State ____		
Sex Male Female	***Marital Status***	Single	Married	Separated	Divorced	Widowed

- I consent to nasopharyngeal testing for COVID-19.
- I understand that I may seek medical evaluation by a physician at CI Medical Center prior to testing, but I have declined this option.
- I understand that I can obtain results from CI Medical Center via the patient portal (if I provide a valid email), by calling on the phone or coming to the facility for a hard copy of the test results. I understand that my COVID-19 test results cannot be faxed or email.
- I understand that CI Medical Center sends out COVID-19 testing to a reference lab and the result's turnaround time is dependent on the reference lab capability.
- I understand that if my result outcome can be negative or positive.
  - **NEGATIVE**
    If the result is negative, this does not infer that I do not have coronavirus, but that the testing result is negative. If I develop symptoms of coronavirus, I understand that I will seek medical advice.
  - **POSITIVE**
    If my result is positive, I understand that it is my responsibility to seek medical advice immediately.

____
Signature

____
Print Name & Date

[Please bring your picture ID. We will need to make a copy of your picture ID for our lab to bill the federal government for COVID-19 testing. This consent form will be shared with our reference lab for billing purposes.]