LONG BEACH HEALTH & HUMAN SERVICES

# Long Beach Provider COVID-19 Test Request Form

Please fax this form to 562.570.4374 or send secure email to LBEpi@longbeach.gov.
Drive thru testing is available Mon through Fri, 9am to 2pm.
Patients who do not meet testing criteria will not be tested.

Date: _____ Time: _____

| Provider Information | |
|---|---|
| Provider Name | |
| Provider Facility | Provider Specialty |
| Provider Address | |
| Provider Phone Number | Provider Fax Number |

| Patient Information | | |
|---|---|---|
| Name | | Date of Birth |
| Address | | Occupation (title & location) |
| Cell Phone | Emergency Contact Name | Emergency Contact Number |
| Reason for test request (S/S, etc. Include any diagnostic testing or imaging that has been done) | | |

| Health Insurance Information | You do not need insurance to get a test. Insurance information does not affect eligibility or scheduling. The test is free. If you have insurance, it may be billed, BUT YOU WILL NOT BE CHARGED (no co-pay, deductible, etc.) |
|---|---|
| Name of Insurance | Group Number |
| Address of Insurance | Policy Number |
| Insurance Phone Number | Policy Holder /Subscriber Information |
| Responsible Party | |

## Consent for Testing:

I (myself, my child, or a minor under my legal care) voluntarily consent and authorize the City of Long Beach Department of Health & Human Services (DHHS) to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by a nasal or oral swab. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

Release of Information and Assignment of Benefits:
I authorize the City of Long Beach Department of Health & Human Services (DHHS) to release information from my medical record to any healthcare provider participating in any way in the care of the patient and to any person or entity which is or may be liable for all or part of the charges for services received. In addition, I authorize my insurance benefits be paid directly to DHHS. I also understand that following release of medical records or information, DHHS will no longer be responsible for the confidentiality of any documents released in accordance with this authorization. I understand that by written notice to DHHS I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it.

Signature _____ Date _____