Form Consent/Release and Waiver and Authorization to Release/Exchange Information (Student)
VIRAL SOLUTIONS LLC and ATLANTA PUBLIC SCHOOLS

Student (Last Name, First Name): ______________________________________

Date of Birth: ______________________________________

School: ______________________________________

As the parent or legal guardian of the above-named student, I hereby give my consent to Viral Solutions LLC ("Viral Solutions") to conduct testing on the above-named person for the COVID-19 virus through a nasopharyngeal swab or saliva test and related professional medical services including any ancillary services related thereto to accomplish the same. This consent extends to multiple test administrations throughout the remainder of the 2020-2021 school year.

I understand that the risks associated with drawing bodily fluid for laboratory examination include, but are not limited to, infection and bleeding. I further grant permission for Viral Solutions employees or contractors to treat the above-named person for any condition that arises on site out of the testing services agreed to under this consent, if necessary, which permission gives Viral Solutions LLC employees or contractors the right to treat such conditions in their sole discretion if within their capabilities but does not require them to do so.

I understand that Viral Solutions employees or contractors providing services on behalf of Atlanta Public Schools are not necessarily physicians or medical doctors, are not employees or agents of Viral Solutions and may be contractors of Viral Solutions, and that Viral Solutions is not liable for their acts or omissions. I understand that the services provided by Viral Solutions relate to the performance of an isolated diagnostic test and are not intended to be a complete medical examination or create any physician-patient relationship.

By supplying my home phone number/mobile phone number/email address, I acknowledge that Viral Solutions or a third-party automated outreach and messaging system may notify me of a pending appointment, missed appointment, lab results, or deliver any other health care message by call, email, or text message. I consent for Viral Solutions or the school listed above, or a third party acting on its behalf, to call or text me at any phone number associated with the above-named person, including through pre-recorded/automated voice and text messages, for the reasons specified above. I understand that my cell phone carrier may charge me for these text messages and that I will be offered an easy way to opt out of these automated calls or text messages.

I acknowledge receipt of Viral Solutions' Notice of Privacy Practices and that Viral Solutions and its licensed and other health care professionals may use and release medical information obtained during any visit for purposes of treatment, payment, and health care operations. Such disclosure may include information provided to any insurance carrier, employer, government or social service agency or other provider of medical benefits for purposes of reimbursement for any part of expenses incurred and for the purpose of evaluation and processing claims for payment for services provided to the above-named person. I authorize and assign all payments of such insurance benefits directly to Viral Solutions LLC.

I authorize Viral Solutions LLC to use or disclose test results of my COVID 19 virus test ("Protected Health Information") to the Atlanta Public Schools (including the School) and any individual involved in the operation of the Atlanta Public Schools, including, without limitation, designated officials and the Superintendent, to inform such individuals of whether I have been tested positive (including presumptive positive) or negative for the COVID-19 virus and to facilitate contact tracing with respect to preventing the spread of the COVID-19 virus. I authorize Atlanta Public Schools to disclose information about me to Viral Solutions LLC as needed to conduct COVID-19 testing and to facilitate contact tracing with respect to preventing the spread of the COVID-19 virus. This authorization expires 12 (twelve) months from the date of signatures noted below.

I UNDERSTAND THAT:

- The Protected Health Information used or disclosed under this authorization may be subject to redisclosure by the receiver and no longer protected by the Standards for Privacy of Individually Identifiable Health Information.
- Treatment, payment, enrollment in a health plan or eligibility for benefits may not be conditioned on whether I sign this

authorization.

- If I have any questions about the disclosure of my Protected Health Information, I can contact Viral Solutions LLC at help@viralsolutionsga.com.

- I may revoke this authorization to use and disclose information, as well as consent for testing, in writing except to the extent that Viral Solutions LLC or Atlanta Public Schools has previously used or disclosed the Protected Health Information in reliance on this authorization and/or administered testing in reliance on consent for testing. To revoke this authorization or consent for testing, I must deliver a signed written statement clearly stating that I revoke this authorization, to Ronald Sanders at Viral Solutions LLC, 2302 Parklake Drive, Suite 513, #1452, Atlanta, GA 30345 and to Dr. Katika Lovett at Atlanta Public Schools, 130 Trinity Ave SW, Atlanta, Georgia 30303.

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Signature of Parent/Guardian Authority or Relationship to Student

______________________________ ______________________________

Signature of Student Date

(if over 18 or otherwise
authorized to consent)