Attached please find the information about the Rapid Antigen and PCR testing we will be doing at New England Music Camp on July 1, 2021, as well as the required forms from the laboratory. We will be working with PMH Laboratory, Inc. (https://pmhlaboratory.com/services/covid-19-group-testing) for the PCR testing, who will send a team of clinicians to NEMC to complete the testing. Our infirmary staff will also be working with the team from PMH, as well as overseeing any necessary rapid testing with the Abbott Rapid Antigen test.

Please complete and submit the forms AFTER June 1, 2021

Please read the attached information carefully, and complete the required forms. Here are a few instructions that will help:

- Page 1, test request form, please check "RT-PCR Test" at bottom after completing all pertinent information, camper or staff sign form
- Page2, parent and camper complete form and sign
- Page 3, keep for your records to obtain the test results after completion
- Page 4, disclosure form, parent and camper sign
- Page 5-6, keep for your records
- Page 7, only complete if your family does not have insurance
- Page 8, NEMC rapid test permission, camper and parent sign

It is our hope that everyone in the camp "bubble" will test negative at this point, and we can continue camp as normally as possible for the remaining 3 weeks. If you have any questions about our Covid protocols, or the testing procedures we will be following, please contact us. We are so very excited to welcome everyone to NEMC in just a few more weeks!!

Kim and Matthew Wiggin,
Directors

Employer / Group Name: _____ Location: _____ Employee □ Family □

COVID-19 IgG Antibody & RT-PCR Test Request Form

Please complete this form and provide a copy of insurance card and identification for at the time of collection.

Laboratory Personnel – FOR OFFICE USE ONLY		
Today's Date:	**Location Name:**	
Clinician Name:	Phone:	
Patient Information: COMPLETED BY PATIENT		
First Name:	Last Name:	Phone:
Address:		
City:	Zip Code:	County:
State:		
Date of Birth:	Age:	Sex: □ Male □ Female
Email:		
Additional Information **required** for testing:		
Does the patient live or work in a congregate setting (e.g., long-term care facility, shelter, group home, prison, jail)		
□ **YES** □ **NO**	Facility Name: Employee Occupation:	
Does the patient receive dialysis? □ **YES** □ **NO**		

CLINICAL INFORMATION: COMPLETED BY PATIENT	
Date of symptom onset: □ None	Does the patient have any underlying conditions?
Symptoms Observed:	□ None □ Immunocompromised
□ Fever □ Runny nose	□ Unknown □ Pregnant
□ Tiredness □ Loss of smell	□ Diabetes □ Chronic Lung Disease
□ Dry Cough □ Diarrhea	□ Hypertension □ Chronic Liver Disease
□ Body Ache □ Loss of Appetite	□ Cardiac Disease □ Chronic Kidney Disease
□ Nasal Congestion	□ Other

LABORATORY TESTING – COMPLETED BY PATIENT	
Has the patient been tested for influenza? Result: □ **Positive** □ **Negative** Test Type: □ **Rapid** □ **PCR**	□ **YES** □ **NO**
Has the patient been tested for any other viral respiratory illness? Result:	□ **YES** □ **NO**

COVID 19 TESTING – COMPLETED BY PATIENT	
Has the patient been tested for COVID-19? Result: □ **Positive** □ **Negative** Test Type: □ **Rapid** □ **PCR**	□ **YES** □ **NO**

I hereby acknowledge full and complete consent for testing and make request for:

□ RT-PCR Test and/or □ SARS-Cov2 IgG Antibody Test (CHECK ONE OR BOTH)

I hereby acknowledge full and complete consent to and make request for a SARS-Cov2 IgG Antibody test. I am physically able to have this blood draw and have never had an adverse reaction to any phlebotomy services. I hereby request and authorize PMH Laboratory, Inc. designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with PMH Laboratory, Inc., to collect this sample for me or the person named above for whom I am the legal guardian. I hereby release The PMH Laboratory, Inc. its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, this SARS-CoV-2 IgG Antibody Test or the administration of same including, but not limited to, acts of negligence. I authorize my medical information herein, including tests results, to be shared with my physician/insurance/employer. The PMH Laboratory, Inc., will use and disclose your personal and health information to treat you, to receive payment for the care we provide, to public health agencies as required, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regard to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 5 minutes after collection of samples. **Please provide a copy of this form to your physician and/or healthcare provider for your medical records.** This test is for informational purposes only and to be discussed with your health care professional. The PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any outcome in your care or treatment. Please keep in mind that a positive result does not mean you are immune or cannot become re-infected. This test was developed, and its performance characteristics determined by PMH Laboratory, Inc. This test has not been FDA cleared or approved. This test has been authorized by FDA under an Emergency Use Authorization (EUA). This test has been validated in accordance with the FDA's Guidance Document (Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency) issued on April 20, 2020. FDA independent review of this validation is pending. This test is only authorized for the duration of time the declaration that circumstances exist justifying the authorization of the emergency use of in vitro diagnostic tests for detection of SARS-CoV-2 virus and/or diagnosis of COVID-19 infection under section 564(b)(1) of the Act, 21 U.S.C. 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.

PATIENT SIGNATURE:_____ DATE:_____

5862 Edinger Ave ◊ Huntington Beach ◊ CA ◊ 92649 ◊ (562) 592-2890 Office ◊ (909) 803-9790 Fax
CLIA 05D2137011 ◊ STATE CLF351210 ◊ COLA 028736
Rahil R. Khan, MD – Laboratory Director

STUDENT AUTHORIZATION

To Disclose COVID-19 Diagnosis or Exposure (School Name:_____)

I Understand that the Americans with Disabilities Act, the Family and Medical Leave Act, the California Confidentiality of Medical Information Act, and other privacy laws prohibit my school listed above and/or education provider from disclosing my medical/health information. In the interest of the health of my classmates, faculty, school and others with whom I may have had contact with, I authorize the School Nurse and/or Administration to disclose to other students, faculty and school staff at my school and to others, i.e., other parents, visitors, customers, vendors, whom I may have encountered at my school, that I have tested positive for the COVID-19 virus or that I have been exposed to the virus by being in close conatact with someone who is believed to be infected with the virus. PMH Laboratory, Inc. has advised me that I am not required to do so and that there would be no adverse consequences to my education if I chose not to do so. Further, my school listed above did not seek to coerce or pressure me to permit the disclosure.

In disclosing this information, *the school listed above* will take reasonable measures to keep my name and identity confidential to the extent possible, though I recognize that circumstances may require identifying me as the infected or exposed individual in order to properly warn others so they may take precautionary measures and help prevent further speread of the virus, and that there are times when it is not possible to inform others they may have been exposed to the virus without them learning that it was through contact with me.

This authorization expires 30 days from, the date this document was signed, after which the school will no longer be authorized to disclose this information. I have been advised that I have a right to receive a copy of this authorization.

_____ _____

Signature of Individual (Student) Date

_____ _____

If a minor, Signature of Legal Guardian (Parent/Guardian) Date

_____

Printed Name of Individual (Student)

SIGNING THIS AUTHORIZATION FORM IS VOLUNTARY

5862 Edinger Ave. Huntington Beach, CA 92649 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com

Hello:

Your results are now ready for you to view. Please go to www.pmhlaboratory.com to register and access your results. Results are typically avaialble after 48 hours from the date the specimen is received in the lab. Please keep in mind that if your results are not yet ready you will be told that your email address and/or password is not on file and you will not be able to log into the system. If after 48 hours, you are still unable to access your results, please contact us at (562)592-2890 and ask to confirm that the email address we have on file for you is correct. If you are still unable to see your results, call and we can send your results via Neo-Certified secure email.

To access your results please click on the link above and the follow the instructions below:

1. Click the "Sign In" icon located under "Patient Test Results";
2. Once you are on the Patient Portal click the "Register" tab;
3. Enter the email address that wasprovided at the time of testing (NOTE: Only one results can be sent per email address. If there are several in your group using the same email, each person need to contact the lab and provide a different email address in order to access each person's results);
4. Click on the box regarding the Terms of Service. You must agree to the terms in order to register and access results;
5. An email will then be generated to the email address provided instructing you to set your password;
6. Once you have set a password, you will need to return to the login page and login using the email and password;
7. You should then be directed to your results.

If you are unable to access your results after following the instructions above, please do not hesitate to contact us. We will be happy to help you further and answer any questions you might have.

Thank you for choosing PMH Laboratory, Inc.

Sincerely,
PMH Laboratory, Inc.

AUTHORIZATION
To Disclose COVID-19 Diagnosis or Exposure

I Understand that the Americans with Disabilities Act, the Family and Medical Leave Act, the Calaifornia Confidentiality of Medical Information Act, and other privacy lasws prohibit my employer from disclosing my medical/health information. In the interest of the health of my co-workers and others with whom I may have had contact on my worksite, however, I authorize ***Company Name,*** Human Resources Department and/or senior management to disclose to employees at my worksite and to others, i.e., clients, visitors, customers, whom I may have encountered at my worksite, that I have tested positive for the COVID-19 virus or that I have been exposed to the virus by being in close conatact with someone who is believed to be infected with the virus. PMH Laboratory, Inc. advised me that I am not required to do so and that there would be no adverse consequences to my employment if I chose not to do so. Further, ***Company Name*** did not seek to coerce or pressure me to permit the disclosure.

In disclosing this information, (employer) will take reasonable measures to keep my name and identity confidential to the extent possible, though I recognize that circumstances may require identifying me as the infected or exposed individual in order to properly warn others so they may take precautionary measures and help prevent further speread of the virus, and that there are times when it is not possible to inform others they may have been exposed to the virus without them learning that it was through contact with me.

This authorization expires30 days from, the date this document was signed, after which ***Company Name*** will no longer be authorized to disclose this information. I have been advised that I have a right to receive a copy of this authorization.

_____ _____

Signature of Individual (Employee) Date

_____

Printed Name of Individual (Employee)

SIGNING THIS AUTHORIZATION FORM IS VOLUNTARY

5862 Edinger Ave. Huntington Beach, CA 92649 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com

CONSENT FOR VENOUS PUNCTURE

I hereby acknowledge full and complete consent to and make request for a venous blood draw. I am physically able to have this blood draw and have never had an adverse reaction to any phlebotomy services. I hereby request and authorize PMH Laboratory, Inc. designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with PMH Laboratory, Inc., to collect this sample for me or the person named above for whom I am the legal guardian. I hereby release The PMH Laboratory, Inc. its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, venous blood draw or the administration of same including, but not limited to, acts of negligence. I have voluntarily requested this venous blood draw outside the course and scope of my employment. The PMH Laboratory, Inc., will use and disclose your personal and health information to treat you, to receive payment for the care we provide, to public health agencies as required, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regard to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 5 minutes after collection of samples. This test is for informational purposes only and to be discussed with your health care professional. The PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any outcome in your care or treatment.

PATIENT NAME (*Please print)*:_____

PATIENT SIGNATURE:_____

DATE:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

PMH Laboratory, Inc, its affiliates, subsidiaries and/or divisions (collectively referred to as "PMH Laboratory") is required by law to provide you with this notice explaining PMH Laboratory's privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment and health care operations, as well as for other purposes that are permitted or required by law. PMH Laboratory is required by law to follow the procedures described in this Notice of Privacy Practices as long as the Notice remains in effect. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

PMH Laboratory is required to protect the confidentiality of your protected health information and to inform you if your protected health information has been acquired, accessed, used or disclosed by unauthorized persons.

WHAT IS PROTECTED HEALTH INFORMATION?

Protected Health Information (PHI) includes both medical information regarding your care and treatment and individually identifiable personal information such as your name, address, phone number, social security number or other personal information that you provide in the course of your treatment. This information may be in electronic, written and/or oral form.

HOW PMH LABORATORY MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
PMH Laboratory may use and disclose PHI about you, without your authorization, for the purposes described below.

Treatment: PMH Laboratory may use and disclose your health information to provide, coordinate or manage your healthcare by us and other healthcare providers. This includes, but is not limited to, disclosures about you to doctors, nurses, technicians, staff and other healthcare professionals who become involved in your care.

Payment: PMH Laboratory may use and disclose your health information to receive payment for services provided to you, or to obtain prior authorizations for proposed treatments.

Healthcare Operations: PMH Laboratory may use your health information for our own operations. We may also use and disclose your health information to health professionals for educational purposes. These uses are required to run our company and to make sure that all of our patients receive quality care.

Treatment Issues: We may call you with test results or to answer your questions about your care, or use and disclose health information to inform you about treatment options and alternatives.

Health-Related Benefits and Services: We may use and disclose personal and health information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved In Your Care or Payment For Your Care: Unless you object, we may disclose your health information to a relative, friend or any person identified by you, if these individuals need to know about or are involved in your care, or for payment for your care.

Workers Compensation: PMH Laboratory may disclose your health information in order to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

Public Health, Safety, Disaster Relief, Or to Divert a Threat to Health Or Safety; Victims of Abuse, Neglect, or Domestic Violence: PMH Laboratory may use or disclose your health information to the extent necessary for public health activities and to avert a serious and imminent threat to your health or safety or the health and safety of others. PMH Laboratory may disclose your personal and health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes. Any disclosure would only be to someone able to help prevent the threat or injury.

Health Oversight: PMH Laboratory may disclose your health information to a health oversight agency for activities authorized by law. This may include but is not limited to The Joint Commission, ACHC, surveys, investigations, inspections, licensure or disciplinary actions.

Legal Proceedings and Law Enforcement: PMH Laboratory may disclose your health information if asked to do so by a law enforcement officer and/or in response to a subpoena, court or administrative order, warrant, discovery request or other lawful process.

Military and National Security: PMH Laboratory may disclose your health information to authorized military command authorities or federal officials if you are in the armed forces or are a veteran, or as required for lawful intelligence, counter intelligence and other national security activities.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner or medical examiner if necessary to identify a deceased person or to determine a cause of death, or to a funeral director in connection with the performance of their duties.

Business Associates: PMH Laboratory may provide some services through contracts with business associates. In those instances, PMH Laboratory requires the business associates to safeguard your information through a Business Associate Agreement.

Research; Death; Organ Donation: PMH Laboratory may use and disclose your health information for research purposes in limited circumstances. However, all such research projects are subject to an approval process, and we will ask your permission if a researcher is to have access to your name, address, or other information that identifies you. PMH Laboratory may disclose your health information for the purpose of facilitating organ donation and transplantation.

Required By Law: PMH Laboratory will use or disclose your health information when required to do so by federal, state or local law.

USES OR DISCLOSURES NOT COVERED BY THIS NOTICE.
Uses or disclosures of your health information not covered by this notice or the laws that apply to PMH Laboratory may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

YOUR RIGHTS REGARDING YOUR PERSONAL AND MEDICAL INFORMATION.
Although your medical record is the property of PMH Laboratory, the information belongs to you. Federal law gives you the rights described below regarding your medical information.

Inspect and Copy. With some exceptions, you may review and copy your medical information. To the extent your record is maintained electronically, you have the right to access your own electronic health record in an electronic format. You may also direct PMH Laboratory to send the e-health record directly to a third party.

Amendments. You may ask us to amend your medical information if you feel it is incorrect or incomplete. However, we may deny your request under certain circumstances.

Accounting of Disclosures. You may request a list of certain disclosures made of your medical information ("accounting of disclosures"). In some instances, the accounting may be limited by time and may exclude disclosures made for treatment, payment or health care operations.

Right to Request a Restrictions. The HIPPA Privacy Rule provides that you may request a restriction on the protected health and medical information the Plan uses or discloses about you for payment or health care operations. If you pay for your services, in full, using your personal funds, you can ask that the information regarding the service not be disclosed to a third-party payer since no claim is being made against the third-party payer. This request must be made in writing and we are not required to agree with your request.

Right to Request Confidential Communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Plan communicate with you in an alternative manner or at an alternative location. You may request that we communicate with you about medical matters in a confidential manner or at a specific location. This request must be made in writing.

Paper Copy of This Notice. You may request a paper copy of this notice at any time by contacting your local PMH Laboratory office or PMH Laboratory's Privacy Officer. You may obtain an electronic copy of this notice at our website: www.wellnessgrp.com.

To exercise any of these rights you must: submit your request in writing to your local Wellness Group office or PMH Laboratory's Privacy Officer. Your request should include a reason for your request and, if applicable, the action you want PMH Laboratory to take. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will notify you of the cost involved and you may choose to change or take back your request at that time before any costs are incurred.

BREACH NOTIFICATION REQUIREMENTS: PMH Laboratory is required to notify you if unsecured PHI is acquired, accessed, used and/or disclosed by an unauthorized party. Notification must occur without unreasonable delay and no later than 60 days of the event.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each PMH Laboratory office and on its website (www.wellnessgrp.com). In addition, if material changes are made to this notice, the notice will contain an effective date for the revisions and copies can be obtained by contacting your local PMH Laboratory office or PMH Laboratory's Privacy Officer.

EFFECTIVE DATE: This Notice of Privacy Practices is effective January 1, 2020.

QUESTIONS/GRIEVANCES: If you want further information about matters covered by this notice, are concerned that your privacy rights may have been violated, or disagree with a decision made about access to your personal and health information, you may contact PMH Laboratory's Privacy Officer by U.S. mail, fax, phone or email at: **PMH Laboratory, Attention: Privacy Officer, 5862 Edinger Ave Huntington Beach, CA 92649; (562) 592-2890 Fax: (909) 803-9790; e-mail: info@pmhlaboratory.com.** You may also submit a grievance/complaint to the U.S. Department of Health & Human Services, 200 Independence Ave., SW, Washington DC 20201, Phone: 202.619.0257, Toll Free: 1.877.696.6775.

PMH Laboratory will not retaliate and you will not be penalized in any way if you choose to file a grievance complaint with us or with the U.S. Department of Health and Human Services.

Date: _____

HRSA COVID-19 Uninsured Program

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Gender: _____ Social Security Number: _____

State of Residence: _____ Driver License # : _____ Date of Service: _____

PMH Laboratory, Inc attest that we attempted to capture the above information prior to submitting a claim.

I certified that the above patient has no Insurance, Federal, Private, nor Medicare coverage. Patient status is uninsured.

Patient signature: _____

* Attach a copy of Driver License and Social Security Card.

5862 Edinger Ave. Huntington Beach, CA 92649 • (562) 592-2890 *Office* • (909) 803-9790 *Fax* • info@pmhlaboratory.com

New England Music Camp

Rapid Antigen Testing Permission

I give permission to the administration and health center staff at New England Music Camp to administer the Abbott Rapid Antigen test to my child _____ upon arrival at camp, and if they demonstrate any Covid 19 symptoms during the camp season. I understand that I will be contacted by a staff member if the test result is positive, and my child will remain in quarantine at the health center until a negative test result is obtained.

Parent/guardian name (print): _____

Child name (print): _____

Parent signature: _____

Date: _____