Florida Laboratory Analysis

6900 Southpoint Dr N Suite 210
Jacksonville, FL 32216

# Patient Affidavit and Consent

## HRSA Covid-19 Uninsured Program

***IF YOU HAVE INSURANCE, DO NOT USE THIS FORM***

All Fields in this Section are REQUIRED

*Date of Collection: _____

*First Name: _____ * Last Name: _____

*Date of Birth: _____ * Gender: ◯ Male / ◯ Female (Circle/select one)

*Address: _____

_____

Note: If the individual is unable or unwilling to provide their address, please add the address of the facility where the care was provided or other location that may be appropriate (i.e. shelter).

PLEASE FILL OUT SECTION 1 AND SECTION 2:

1) * SOCIAL SECURITY NUMBER: _____- _____ - _____
   * STATE OF RESIDENCE: _____

2) * STATE-ISSUED IDENTIFICATION/DRIVERS LICENSE #: _____

PLEASE REAND AND SIGN BELOW:

I, the undersigned patient, hereby verify that I am currently in possession of a medical prescription from a physician or other qualified health care practitioner with instructions for me to be tested for COVID-19. I certify under penalty of law that I do not possess ANY kind of health insurance that might possibly reimburse Florida Laboratory Analysis, LLC for the cost of this testing.

Patient's Signature: _____ Date: _____

Attestor's Signature: _____ Date: _____

**NOTE: Florida Laboratory Analysis, LLC is a medical laboratory and does not have direct contact with patients. Florida Laboratory Analysis relies on the attestation of the ordering health care provider that the aforementioned patient's health coverage status is uninsured. By this form, Florida Laboratory Analysis is making its best efforts to confirm that the patient was uninsured at the time the services were provided.**