

Informed Consent Form COVID-19 Testing

This Informed Consent Form (“**Consent**”) describes the COVID-19 diagnostic testing process (“**Test**”), including what will happen, what information will be collected from you, as well as who can use and disclose that information and for what purposes. The Test is performed under a workplace safety program established for a commercial production in which you are involved, and the testing program was designed to be consistent with industry safety guidelines and applicable protocols issued by the local public health agencies.

What will happen during the testing process?

If you decide to undergo testing subject to the terms of this Consent, you will be provided with access to a copy of the FDA patient fact sheet and offered testing using an appropriate method of specimen collection as authorized by the FDA through specific Emergency Use Authorization (EUA) by testing type. Production site staff will provide testing time options to you and others based on production schedules. From time to time, there may be reasons why an individual may need to resubmit a sample or experience a delay in testing results.

Tests will be paid for by your employer or its subsidiaries (“**Production Company**”). Testing services will be provided by your employer and its affiliated or contracted providers and will include physician oversight of Tests, such as evaluation of Test requests, ordering of Tests, receipt of Test results (“**Results**”), notification of abnormal or positive test results, associated consultation regarding testing, and any other related services provided by Provider.

The Test is a CDC-approved SARS-CoV-2 molecular test to determine if you currently have COVID-19. This test has been laboratory developed, validated, and authorized for use during the COVID-19 Pandemic as defined by the EUA, Provider will use a combination of testing methods that include, but are not limited to, testing which utilizes a polymerase chain reaction (“PCR”) testing process via nasopharyngeal or nasal swab and which may be collected on-site by Provider or at-home by the individual and sent to a third party laboratory for confirmation, and/or molecular point-of-care testing process via oropharyngeal, nasopharyngeal or nasal swab.

Except as authorized below, Provider will keep Results confidential in accordance with HIPAA and state and local privacy laws. Provider will also ensure that any of its representatives or third parties with whom it shares the Results as permitted below understand that they are also bound by HIPAA and state and local privacy laws in their handling of the Results.

Your Results will be made available to you, together with sufficient information to understand what the results mean, such as the FDA Fact Sheet and counseling for detected test results and including the date the sample was taken. Provider will share your Results with the **Production Company’s COVID-19 Compliance Manager** (“Compliance Manager”) who needs a copy to determine if you are “cleared” or “not cleared” to work, as well as the **Executive in Charge** of your production. The contact information of the Compliance Manager will be made available to you. Provider and/or an employer-designated medical professional will call you to review any Positive Results, offer education, explain the next steps you should take, and answer any questions you may have. They may also follow-up with you on any symptoms and experience. Provider and/or an employer-designated medical professional may leave a voicemail, but will not include any Results in such message. You should consult your personal physician with any additional questions.

In certain circumstances, your Results and certain other information about you will be reported by Provider to the relevant public health authorities, as required by law (further described below).

What information will be collected from me?

The following information may be collected from or about you:

- **Demographic Information:** This may include information (including identifiers) such as your first and last name, date of birth, phone number, email address, home address (including zip code), gender, and race/ethnicity, or other information that may be required by applicable law. This information is collected only to verify your identity, process your lab test, and meet mandatory reporting requirements.
- **Testing Information:** Results of your COVID-19 test (positive, negative, or inconclusive), as well as dates and times associated with sample collection and certain other processing activities.
- **Consent:** A record of this Consent, along with your name, will be maintained by Provider.

Who can use and disclose my information, and for what purposes?

- Provider may have access to certain demographic information, testing information (including Results), and this Consent, to assist with the ordering and administration of Tests.
- Production Company may collect and send certain demographic information to Provider in advance of testing, to allow Provider to prepare the Tests.
- Production Company may receive from Provider certain aggregated information (i.e., information that will not identify you as an individual), including the total number of Tests performed, to monitor testing progress and testing capacity.
- If required to do so by clients, agencies, advertisers, or other third-parties directly involved in the production, Production Company may disclose whether cast and crew are “cleared” or “not cleared” to work on the production, on an anonymous basis.
- The Compliance Manager at your production site will have access to certain demographic information and testing information, including your Results, to be used for contact tracing purposes. In addition, Provider may provide the Compliance Manager with your Results any time Provider determines that such information is needed for the Compliance Manager to make a determination that it is safe for you to return to the production site. Information provided to the Compliance Manager will be stored on Production Company’s or Provider’s systems and maintained in accordance with HIPAA and/or any applicable state and local privacy laws.
- The Compliance Manager may disclose to **Production Company’s safety department contact** your Results solely for contact tracing purposes, and may also disclose your name and/or other identifying information only as necessary to conduct contact tracing.
- The Compliance Manager may inform **limited production site staff** who handle the production schedule that the production schedule should be shifted based on those individuals who have positive or inconclusive Results; however, these production staff will not receive any directly identifying information about those with positive or inconclusive Results, such as name.
- If your Results are positive, Provider, as well as Production Company in some instances, are required by law to report certain information about you, such as your full name, home address, phone number, gender, race/ethnicity (if provided), and date of birth, to **relevant health authorities** for public health purposes. The Production Company will provide you with a copy of its plan in the event you or a co-worker test positive.

How long will my data be kept?

Provider, as well as Production Company in some instances, will retain your demographic information, testing information, and Consent for as long as required by applicable law. Production Company may retain aggregated information across all Test participants (such as total number of Tests performed) for the duration of the testing program.

Who can I contact if I have questions?

If you have any questions before or after the Test, you can contact Provider, whose information will be provided to you at the time of service, if requested or as otherwise applicable.

Consent

I acknowledge and agree to the following:

- I am the individual who will provide the sample for the requested Test(s).
- I am eighteen (18) years of age or older, or my parent/legal guardian has consented on my behalf.
- I understand that testing is voluntary. However, if I chose not to take part in testing, I understand that I may not be able to take part in the production.
- I understand that I may withdraw my consent to testing at any time prior to the completion of the Test(s) by contacting the Compliance Manager.
- I agree to receive the testing services provided by Provider as described in this Consent.
- I agree that my information, including my Results, will be used and disclosed only as described in this Consent. I understand that if my Results are positive, that those Results and certain other information about me will be reported to relevant public health authorities as required by law.
- I understand that the Tests are not being performed for treatment purposes or to treat any condition, disease, or illness. I understand that Provider will provide no treatment or prescriptions related to any of the Tests. I am responsible for forwarding any Results to my primary care or other personal physician and for initiating follow up with such physician for care, diagnosis, or medical treatment.
- I understand that the Tests have inherent limitations and, like many laboratory tests, there is a chance of a false positive or false negative result, but that the Producer has selected a test with the goal of minimizing these outcomes.
- I am responsible for following instructions regarding receiving my results as described in this Consent.
- I am responsible for contacting Provider to notify them of any changes to my mailing address, email address, phone number, or other information that I provided in connection with this testing program during the course of production.

I have read this Consent carefully, and all my questions were answered to my satisfaction. I hereby consent to participate in Provider's services, including the performance of the Test(s) that I have requested, pursuant to the terms, conditions, standards, and requirements set forth herein,

Name:

Signature:

Date:

HIPAA Authorization Form

If you agree to undergo testing, your Test will be administered and collected by Provider. To allow the **Production Company** to receive your Results and related testing information, you will need to authorize Provider to release your Results to the **Production Company's COVID-19 Compliance Manager** and the **Executive in Charge** of the production (these two positions collectively referred to hereafter as "**Authorized Personnel**").

You have certain rights to privacy regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("**HIPAA**"). By completing and submitting this HIPAA Authorization Form ("**Authorization**"), you are authorizing Provider or its/their designee to disclose your Demographic Information (including for example, name, date of birth, email address, home address, phone number, gender, and (if provided) race/ethnicity) and your Results to the Authorized Personnel solely for the purposes described in the Informed Consent Form accompanying this HIPAA Authorization. This Authorization applies to the disclosure of your initial Test to the Authorized Personnel and any additional testing you receive as part of this testing program, until this Authorization expires or you revoke your Consent, whichever is earlier.

This Authorization will expire at the end of production. We will ask for a new Authorization at the beginning of each new production for the duration of the testing program. You may revoke this Authorization by notifying Provider in writing. The revocation will take effect upon receipt by Provider, except to the extent that Provider or others acted in reliance upon this Authorization prior to its being revoked.

If you refuse to sign this Authorization, you will not be able to receive the Test and may not be able to participate in the production. You have a right to receive a copy of this Authorization.

I understand for answers to questions about the privacy of my health information I may contact Provider at: _____.

By signing below, I certify that I have read this Authorization and authorize Provider to disclose my information to Production Company as described in this Authorization.

Name:

Signature:

Date:

Name of Parent/Legal Guardian:

Signature of Parent/Legal Guardian:

Date: