



COVID-19 INFORMED CONSENT FORM AND WAIVER

I am aware of the risk of exposure to COVID-19 at Northeastern Nevada Regional Hospital and, with that knowledge, voluntarily request visitation with (patient name) _____ in (room number) _____.

I understand that if I am exposed to and subsequently test positive for the COVID-19 virus as a result of my visitation, it may result in hazards to my health including, but not limited to, breathing problems, heart problems, and/or other complications, possibly including hospitalization and death.

I have been offered visitation but understand that I am not required to visit given the associated risks.

I am voluntarily choosing visitation with the full understanding of such risks and agree that the hospital will not be held liable if I subsequently experience any negative health conditions as a result of being allowed to visit. I understand that if I develop symptoms of COVID-19 after visitation has occurred, NNRH will not be responsible for any testing or treatment for this virus. I should instead contact my primary care physician for all concerns related to COVID-19 after my visit.

I have been given an opportunity to ask questions about my risk of COVID-19 and believe that I have sufficient information to give this informed consent.

Furthermore, during this visitation, I agree to strictly comply with the Northeastern Nevada Regional Hospital Personal Protective Equipment (PPE) requirements and associated COVID-19 policies which include physical distancing of six feet.

I acknowledge that I have received training on PPE use and will comply with such training by keeping all PPE on during my visit.

This form has been fully explained to me, I have read it or have had it read to me, the blank spaces have been filled in, and I understand its contents.

Visitor Name (print)

Visitor Signature

Date

Witness Name (print)

Witness Signature

Date