

I voluntarily request and consent that a pharmacist, pharmacy intern, or pharmacy technician employed or contracted by Hy-Vee, Inc. (“Hy-Vee”) or affiliate or subsidiary of Hy-Vee (collectively, the “Practitioner”) administer to me the COVID-19 test (the “Test”).

I acknowledge that Hy-Vee will give me a copy of the Patient Information Sheet for the Test via the online portal (the “Patient Information Sheet”), which contains information about the Test, and I have carefully read and understand this Patient Information Sheet. I acknowledge that prior to receiving my Test I may ask the Hy-Vee Practitioner any questions about the Test or about information in the Patient Information Sheet. By allowing the Practitioner to administer the Test, it shall be deemed that I fully understand all risks and benefits in connection with the Test and all my questions have been answered to my satisfaction.

I have truthfully answered all the questions regarding myself in the online portal. After careful consideration, I believe that the benefits of receiving the Test outweigh the risks associated with receiving the Test and I have decided to have the Hy-Vee Practitioner administer the Test to me.

I understand that by receiving the Test, my Test results will be sent to applicable state, local, or federal agencies in accordance with state and federal law.

I authorize Hy-Vee to use and/or disclose such Test related information about me, including any medical related information that I provide to Hy-Vee or that is created or received by Hy-Vee that Hy-Vee reasonably determines is necessary to carry out my treatment or conduct its health care operations. This authorization includes disclosures to eTrueNorth, regulatory agencies, public health agencies, billing companies, interpreters and other persons involved in my treatment.

I authorize the information concerning the Test(s) to be forwarded to my primary care physician, authorizing physician, if applicable. This authorization is effective for one year from the date on which it is signed. I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon it. Hy-Vee does not require agreement with the authorization in order to provide services; however if the services are solely for the purpose of creating a medical report for a third party, those services are subject to cancellation if authorization to release the information is not provided. I understand that the person or entity that receives my information may not be covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with a

covered person or entity and the medical information may no longer be protected by the regulations.

Hy-Vee shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Test to me by the Hy-Vee Practitioner. I, for myself, my heirs, executors, personal representatives, and assigns, hereby release Hy-Vee, its employees and contractors, specifically the administering Practitioner, its agents or representatives from any and all claims arising out of, in connection with, or in any way related to my receipt of the Test from Hy-Vee as allowed by applicable law.

I understand that no third-party reimbursement, including Medicare or Medicaid reimbursement, will be submitted for this test. There are other testing locations which offer free tests, and testing which is covered by Medicare and Medicaid. However, at this location, no third-party reimbursement will be sought, and the individual understands and agrees to pay out of pocket for the cost of the test.