COVID-19 CONSENT FOR POTENTIAL CONTACT TRACING

Name (please print):

I understand that my name and contact information may be shared with the local health department (Chicopee) and/or the state health department (Massachusetts) in the event that a client or practitioner at this facility (362 Front Street) tests positive for COVID-19.

My contact details will only be shared in the event that they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

Client Signature: _____ Date: _____