Consent and Authorization for SARS-CoV-2 and COVID-19 Testing

This form is presented in connection with Sema4's COVID-19 monitoring and testing program (the "Testing Program") requested by the school you attend, visit or at which you work (referred to herein as the "School"). You must review and sign both sections (by selecting "I agree" below) in order for you to participate in the Testing Program. If you are under eighteen (18) years of age, a legal representative who is at least eighteen (18) years of age and has the legal authority and capacity to do so must sign this consent and authorization on your behalf.

Test Consent

I hereby request that Sema4 perform testing related to SARS-CoV-2 and COVID-19, as requested by the School in connection with the Testing Program. I have received adequate information regarding this testing, and I understand that specimen(s), such as a nasopharyngeal (nose), oropharyngeal (throat), and/or saliva, will be collected from me in connection with this testing. I understand that a result of "not detected" reduces, but does not eliminate, the possibility that I carry SARS-CoV-2, and (where applicable) that a result of "detected" for antibodies to SARS-CoV-2 does not guarantee that I am immune to COVID-19. I understand that no test will be performed on my sample(s) other than the one(s) authorized by me.

Biobanking for COVID-19 and Other Research: I agree that Sema4 may de-identify and then store and use the sample(s) and information I provide in connection with the Testing Program to support medical and academic research relating to SARS-CoV-2 and COVID-19 and other scientific purposes. Data and information are "de-identified" as defined by HIPAA by removing any information that could be used to identify a specific person, such as a name, email address, or date of birth. Any such research that results in medical advances, including new products, tests or discoveries, may have potential commercial value and may be developed and owned by Sema4 or the researchers that analyze my sample. I understand that if any individuals or corporations benefit financially from studying my sample, no compensation will be provided to me. Sema4 has no obligation to retain my sample(s) indefinitely. I may withdraw this biobanking research consent by emailing privacy@sema4.com. I understand that this consent is being obtained in order to ensure that I understand the Testing Program and the test(s) that will be performed on my sample(s). I understand that the results of this testing may become part of my medical record and may only be disclosed to individuals who have legal access to this record or who I designate to receive this information, including the organization implementing the Testing Program, as set forth below.

Authorization to Release Information to My School

I authorize Sema4 to disclose information from the Testing Program to my School, including my results from the tests performed by Sema4 if requested by my School under the Testing Program, and I authorize my School to use this information to manage the return of students, staff and other individuals, including me, to its properties. Unless revoked by me at an earlier time, I understand that this authorization will expire at the earlier of the end of the Testing Program or ten years from the date of this authorization. I understand that, following such disclosure, this information may be disclosed to others and may no longer be protected by current state and federal privacy regulations. I understand that I may revoke this authorization at any time by providing written notice to Sema4, including by emailing privacy@sema4.com, except to the extent that Sema4 has already taken action in reliance on this authorization by disclosing my

testing results to my School. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment or eligibility for benefits. I understand that, because the purpose of the Testing Program is to manage the return of students, staff and other individuals to School locations, Sema4 may refuse to provide me with testing through the Testing Program if I decline to sign this authorization. I understand that a copy of this authorization will be available to me upon request. If my legal representative is signing this consent and authorization, my legal representative is
satisfied that he, she, or they have received enough information to sign on my behalf.

_____ I agree to the Test Consent (required)
_____ I agree to the Authorization to Release Information to My School (required)

_____
Signature of Person Being Tested Date
(or Legal Representative)

_____
Printed Name of Person Being Tested

_____
Name of Legal Representative (if person being tested is under 18 years old)

_____
Relationship of Legal Representative to Person Being Tested

_____
Personal Email Address (cannot be MPS email address) (required to access results)

_____
Cell Phone Number

_____
Home Address