



## COVID SWAB TESTING

Location Jackson Municipal Airport Authority Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Race  White  Black  Indian  Asian  Other Ethnicity  Non-Hispanic  Hispanic

I authorize the release of my records for COVID-19 testing to Jackson Municipal Airport Authority

\_\_\_\_\_  
Signature of patient

