

TrustCareHealth™

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 results for COVID-19 testing to Jackson Municipal Airport Authority

Signature of patient

