WELLNESS LAB SCREENING

CONSENT FORM

BY SIGNING YOUR CONSENT, YOU:

1. Allow your blood to be drawn.
2. Request to be tested.
3. Agree to make payment in full to Powell Valley Healthcare at the time of service and understand that no other billing will occur to any third party.
4. Agree to take responsibility for providing your physician or healthcare provider with the results.
5. Understand that your laboratory results will be mailed to you at the address you have provided below.
6. Understand that Powell Valley Healthcare laboratory will attempt to reach you by phone at the number you have provided below if abnormal results fall within the criteria established by Powell Valley Healthcare laboratory policy.
7. Understand that your laboratory results **WILL NOT** be made a part of your Medical record or patient chart.
8. Understand that we **DO NOT** interpret results.
9. Understand that we **DO NOT** practice medicine or offer treatments.
10. Accept our privacy practices.
11. Consent to follow-up testing (at no cost to you) if an exposure to your blood occurs.

Signature:____

Mailing address:

Name:_________________________________

Address: ______________________________

City/State: _____________________________ Zip:______________

Phone: _______________________________

Alternate phone:________________________