



PATIENT INFORMATION RELEASE & CONSENT FORM

Initial _____

I understand that test results reported by ADVANCED SCREENING & WELLNESS will be reported directly to me, in the manner I have chosen in the "Step 5" box below. I further understand that it is my responsibility to consult my own medical doctor for interpretation, analysis, evaluation, and explanation of my test results. I understand that neither ADVANCED SCREENING & WELLNESS nor its ordering physician will analyze, evaluate, critique, review or otherwise interpret the results of said tests. I agree that ADVANCED SCREENING & WELLNESS, its officers, shareholders, directors, employed physicians, or its other agent or employee shall not be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, un-interpreted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or causes of action.

Initial _____

I certify that I am not a recipient (beneficiary) of Medicare, Medicaid, Tricare or any other government health insurance benefits, nor will I seek to be reimbursed by Medicare, Medicaid, Tricare or any other government insurer/payor for the test(s) performed. I agree that I am personally financially responsible for payment of fees for all tests ordered and collected by ADVANCED SCREENING & WELLNESS at my request.

Initial _____

I understand that the blood and/or urine tests performed at ADVANCED SCREENING & WELLNESS are done at my request to be screened through either blood and/or urine testing. I further understand that a physician employee of ADVANCED SCREENING & WELLNESS who is licensed under state law to order such testing will do so. I also understand that ADVANCED SCREENING & WELLNESS is a collection facility and that the actual testing will be performed by a third party laboratory, certified to perform such testing on my urine and/or blood specimen collected by ADVANCED SCREENING & WELLNESS. I understand and agree that ADVANCED SCREENING & WELLNESS will report the results of the testing directly to me, my physician, or any health professional I request. I consent and authorize that such disclosure may be made by fax, by mail or by direct pick-up. I understand and agree that the services provided by ADVANCED SCREENING & WELLNESS and the test results from the Lab will be maintained as confidential, protected health information by ADVANCED SCREENING & WELLNESS as required by federal and state law.

Initial _____

I understand that the test results may become part of my medical record. I also understand that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of my insurance policy(ies). I hereby consent to the release of my urine and/or blood test results by ADVANCED SCREENING & WELLNESS to me in the manner I have chosen below and my physician or any other healthcare provider I designate. I understand that my test results will only be provided to other third parties upon my express consent.

Initial _____

All of the above has been discussed with me and I have had an opportunity to have any questions answered that I may have regarding my rights to privacy by an employee of ADVANCED SCREENING & WELLNESS. I have received a copy of Notice of Privacy Practices, as required by HIPAA from ADVANCED SCREENING & WELLNESS or I have chosen not to receive a copy.

Initial _____

I have read and agreed to all the above terms.

Patient Signature

Date

Witness Signature

Date

CHOOSE PREFERRED METHOD OF RECEIVING THE RESULTS*: (Choose One)

US Mail Pickup Fax (_____) _____ Fax to Doctor (_____) _____

* All HIV Tests Must Be picked up in person

Physician's Name _____

INTERNAL USE ONLY: (Verification of Results/Letter)

US Mail Pickup Fax (_____) _____ Fax to Doctor (_____) _____

* All HIV Tests Must Be picked up in person