



AUTHORIZATION TO DISCLOSE HEALTH FAIR INFORMATION

(PLEASE PRINT) I, \_\_\_\_\_ consent to having a blood sample drawn for the purpose of health risk screening. I agree that my individual risks are best known by my Health Care Provider and general review of these screening tests does not substitute for regular medical care. I also consent to having blood drawn for additional tests if requested by written order from my Health Care Provider. These samples will be analyzed at Interpath Laboratory, Inc. The screening test results will be reviewed by an independent Health Care Provider for significant abnormalities, but I understand that I have no other patient-Health Care Provider relationship with the independent reviewing Health Care Provider, and I agree to follow up with a Health Care Provider of my choice to have these screening tests reviewed. Results of other lab tests ordered by your Health Care Provider will be sent directly to that Health Care Provider for review and will not receive independent review.

You may review Interpath Laboratory's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this authorization prior to signing this authorization.

I understand that I have the right to revoke this authorization provided that I do so in writing except to the extent that Interpath Laboratory, Inc. has already used or disclosed the information in reliance on this authorization.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Health Fair Participant)

PLEASE PRINT

Please complete box:  
Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
DOB \_\_\_\_\_ Male/Female \_\_\_\_\_

CDHD ACCT: #4270 (STAFF USE ONLY)

\_\_\_\_\_ #1569 (CMP/Lipids)

Collected: \_\_\_\_\_  
(Date/Time)

Hours Fasting: \_\_\_\_\_

Requisition # \_\_\_\_\_  
(place sticker here)

Patient ID# \_\_\_\_\_

Complete this box for extra tests ordered by physician  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone # \_\_\_\_\_  
Primary Insurance Company Name \_\_\_\_\_  
Insurance ID # \_\_\_\_\_ Insurance Group # \_\_\_\_\_

CDHD-OUTPATIENT Acct: # 4425 (STAFF USE ONLY)

Additional tests:

IP#	TEST	IP#	TEST
3000	CBC (LAV)		
2146	Free T4 (SST)		
2051	Hemoglobin A1C (LAV)		
2147	PSA (SST)		
2090	TSH (SST)		
2179	Testosterone (SST)		
2655	Vitamin D (SST)		