BOONE COUNTY HOSPITAL
Bettering our Community's Healthcare

1015 Union Street Boone, Iowa 515-433-8170

Patient number:_____

Off-Site **Wellness Chem III** Profile Testing Authorization Form

Testing Site: DMACC-Ankeny Campus
Date and Time of Testing: April 18th, 2019 - 0700-0930

*I the undersigned do hereby consent to such examination(s) by Boone County Hospital personnel as may be necessary for participation in the **Community Based Wellness Screening Program**. I further acknowledge that no guarantees have been made to me as to the results of such examination(s) and/or procedure(s).*

I acknowledge that the Boone County Hospital will not release the results of such examination(s) and/or procedure(s) to my personal physicians without my consent.

I hereby authorize Boone County Hospital to release the results of such examination(s) and/or procedure(s) to me by mail and that I am responsible for informing my personal physician of abnormal test results.

_____ _____
Signature Date

Please complete the following information and return to site administrator.

Name: _____ Martial Status: _____

Date of Birth: _____ Sex: M or F

SS# _____

Mailing Address: _____

City, State, Zip: _____

Phone No.: _____ Wellness PSA: ☐ Yes ☐ No *(males only)*

Emergency Contact: _____

Address: _____

Phone: _____ Relationship: _____