Patient number:____________

1015 Union Street Boone, Iowa 515-433-8170

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

Testing Site: DMACC-Carroll Campus
Date and Time of Testing: April 25th, 2019 - 0730-0930

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: ___________________