



1015 Union Street Boone, Iowa 515-433-8170 Patient number: \_\_\_\_\_

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

Testing Site: DMACC-Urban Campus  
Date and Time of Testing: April 10<sup>th</sup>, 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: \_\_\_\_\_