



DIRECT ACCESS TESTING REQUISITION

Participant Name: _____

Date of Birth: _____ Sex: _____ M _____ F

Address: _____ City, State, Zip _____

Phone (Home): _____ Phone (Cell): _____

Table with 3 columns: Test Name, Price, and Please Check. Rows include Wellness Panels (General Health Panel), Individual Tests (General Chemistry, Lipid Panel, CBC, TSH, Hemoglobin A1c, PSA Screening, Vitamin D, Iron Profile, Blood Type, Covid-19 IgG AB), and Radiology Tests (Body Composition). Total cost section at the bottom.

_____ Please mail my results to the address listed above _____ I will pick up my results at CCCH within 3 days

_____ I give permission to _____ to pick up/receive my results

PARTICIPANT INFORMED CONSENT

- I understand that because these test results have not been ordered as a result of my personal medical condition, they are not considered a "covered service" for purposes of insurance, and that it will be my personal responsibility to pay for this testing.
I also understand that the test results will not be maintained under my medical record number, and that the only copy will be mailed to me at the above address. Copies are not kept in my medical record unless I make an appointment with my family provider and take a copy with me to my appointment. Results are only available at CCCH for 30 days past the date of testing.
I understand that no medical professional will review my test results and that the hospital will take no action based on the results.

Signature of participant or participant's personal representative _____ Date _____

Printed Name and Relationship to participant if signed by personal representative _____