Agreement for Laboratory Testing Directly Accessed by Patient

I request laboratory testing and release this clinic from liability for any harm that may come to me as a result of this service.

I understand that blood test results are not a substitute for a medical opinion or consultation, and that provision of such testing to me does not make me a patient of this clinic.

I understand that possible pitfalls include but are not limited to:

- A "normal" lab result may lead me to ignore a physical problem with resulting endangerment of my health. An "abnormal" result may appear to show problems where none exist and could lead me to unnecessary expense, suffering, or risk of further testing.
- The test I have chosen might not be the most appropriate or cost-effective test. I also understand that without a doctor's order, this lab fee will not be billed to nor covered by my insurance.
- The test will be done at a government accredited, inspected laboratory, but even in the best of laboratories, test results are subject to a degree of error that might be misleading to me.

I understand and acknowledge that this laboratory service is required by law (WAC 246-100-076) to report lab results indicative of certain communicable diseases to the State Department of Health. I so consent.

I understand that laboratory work not performed on the order of a physician is not covered by Medicare nor Medicare secondary insurance. I am aware that I have the option of consulting a Medicare physician who might provide this lab work for me under the Medicare program.

Name _____ Date of Birth_____

Phone _____

Address _____

City _____ State _____ Zip _____

Please tell us how you learned about this service _____

Signed_____ Date_____

Thank you!

Witness_____

Important notes:

1. Washington State regulations governing the practice of medicine require us to provide you with pre- and post-test counseling with all HIV tests.
2. Responsible medical practice prevents us from performing certain tests, including genetic testing for paternity, without a physician's prescription.

HIV pre-counseling given _____

Receipt of results

I acknowledge receipt of results of lab testing requested above, and acknowledge that one or more of the lab values is out of the laboratory's normal range.

I understand that it is my responsibility to consult my primary care provider about this abnormal result or about any unexplained medical condition that I might have.

Signed_____ Date_____

Witness_____

HIV post-counseling given _____
(initials and date)