LabDashers

PATIENT CONSENT & HIPAA PRIVACY ACKNOWLEDGMENT

Patient name: _____	**Date of birth:** _____
Phone: _____	**Service date:** _____

1. Consent for Blood Collection

I consent to LabDashers collecting my specimen according to a valid order and delivering it to the laboratory identified by me or my ordering provider. I understand that blood collection may cause temporary pain, bruising, bleeding, dizziness or fainting and, rarely, infection. I may ask questions or stop the collection at any time.

2. Privacy Practices & Use of Health Information

I acknowledge that I received, or was provided electronic access to, LabDashers' Notice of Privacy Practices. The Notice explains how my protected health information may be used or disclosed and describes my privacy rights.

I understand that LabDashers may use or share the minimum necessary information with my ordering provider, the receiving laboratory, authorized couriers or business associates for treatment, payment and health care operations, or when required by law. This acknowledgment is not a blanket authorization for unrelated disclosures and does not waive my HIPAA rights.

3. Communication Preference (optional)

☐ I agree that LabDashers may contact me about appointments or specimen-collection services by phone, voicemail, text or email using the contact information I provided. I understand that ordinary text or email may not be fully secure and I may withdraw this preference at any time.

By signing below, I confirm that I have read and understand this form, had the opportunity to ask questions, and voluntarily consent to the specimen collection described above. I understand that I may receive a copy of this signed form.

Patient/authorized representative signature: _____ **Date:** _____

Printed name: _____ **Relationship:** _____

For LabDashers staff use only

☐ Patient received/accessed the Notice. ☐ Patient declined or was unable to sign; reason: _____

Staff initials: _____ **Date:** _____