A logo with purple flowers and leaves

Description automatically generatedPHLEBOTOMY CONSENT/HIPAA

Consent for services

By-JL Mobile Phlebotomy LLC

You have requested to have your blood drawn by a California state licensed phlebotomist from JL Mobile Phlebotomy. The purpose of this blood draw is to obtain Specimens for laboratory testing.

Procedures: If you agree to this procedure, the following will happen. You will be asked to provide a current driver’s license, a copy of your insurance card and an order/ lab requisition from a licensed physician.

You may also be asked if you have been fasting, if that is required on your order from your physician. You will be asked to provide a urine specimen if needed to fulfill your physicians request for labs ordered.

You will need to fill out and sign the appropriate boxes on your lab requisition if the patient’s portion of information is left blank.

Blood will be taken from a vein in your right or left arm or the top of your right or left hand. The venipuncture will take place at the location of patients home or other specified location agreed upon prior to the visit from the phlebotomist.

The blood draw will take about 20 minutes of your time. After the draw the blood is labeled with your name and date of birth and will be shown to the patient before leaving to verify it is your correct First name, last name and date of birth.

If the blood work needs to be centrifuged prior to dropping off at the lab or mailing center such as fed ex for (kit draws) it will be done prior.

The blood will be packaged and dropped off at the laboratory specified by the physician.

RISKS/DISCOMFORTS:

Some risks/discomforts of having blood drawn include temporary pain from the needle stick, bruising and rarely infection. Some patients may experience dizziness, lightheadedness or rarely fainting. (Please let your phlebotomist know if you have had trouble with this in the past so we can take the appropriate steps for your safety)

If you should feel any of the symptom’s list above during your blood draw, at that time the needle will be removed, and the phlebotomist will proceed to keep the patient comfortable.

Guarantee: You understand that there are times that a blood draw can be unsuccessful due to many reasons such as dehydration. Patients that have or are undergoing Chemo/radiation, children who are uncooperative or no viable veins are just a few reasons a blood draw can be unsuccessful. In this case the phlebotomist will instruct you on how to proceed and what needs to be done.

HIPAA PRIVACY: The health insurance portability & accountability Act of 1966 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclose by us in any form whether electronically, on paper or orally will be kept confidential. The phlebotomist and staff for JL Mobile Phlebotomy will not release any information and will be kept private. Your documents **“Photo ID, Insurance information and Lab slip that you provided”** will be sent to the Lab along with your blood work for processing ONLY.

AUTHORIZATION: I, (patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have read this consent form. I understand everything I have read. All questions that I have asked (if any), have been answered to my satisfaction.

**By signing this consent, I have agreed to this procedure.**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENTS NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT LEGIBLY)

OR:

SIGNATURE OF RESPONSIBLE PARTY TO PATIENT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT LEGIBLY)

RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_