

2023 Health Fair



TRI VALLEY
HEALTH SYSTEM

_____ NUMBER
For Tri Valley Health System Use

Please use your correct **MAILING ADDRESS!**

PLEASE WRITE NEATLY INSIDE THE ADDRESS BOX BELOW. WE USE THIS FORM TO MAIL YOUR RESULTS TO YOU.

NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

DATE OF BIRTH: ____/____/____

AUTHORIZATION

I, the undersigned, authorize Tri Valley Health System to perform diagnostic laboratory tests. I also understand that upon receiving the health fair results, if I have any questions or concerns, I am to contact my medical provider for an appointment.

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT: I have received a copy of the notice. I am the patient or am authorized Initial _____ to act on behalf of the patient to sign this acknowledgment of receipt.

Signature _____

Witness _____

Documentation of Good Faith Effort

_____ **Attempted** to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, **but** the patient/parent/legal guardian **declines** to acknowledge the receipt of the Notice of Privacy Practices.

_____ Patient/Parent/Legal Guardian stated they had **already received** the Privacy Notice at another TVHS service location.

_____ Other

_____ Signature of TVHS Representative attempting to deliver Privacy Notice

Please select which tests you are requesting:

Profile \$55

PSA (men) \$25

TSH (thyroid) \$25

A1C (avg. 3-month blood sugar) \$25

You will receive a guide with an explanation of the “normals” with your test results.

Testing performed at Cambridge Memorial Hospital Laboratory,
PO Box 488, Cambridge, Nebraska 69022

***** TVHS will NOT send your results to your Medical Provider. You *** are responsible to provide a copy to your Medical Provider if you would like them to have a copy of the results.**