



CONSENT FOR VENOUS PUNCTURE

I hereby acknowledge full and complete consent to and make request for a venous blood draw. I am physically able to have this blood draw and have never had an adverse reaction to any phlebotomy services. I hereby request and authorize PMH Laboratory, Inc. designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with PMH Laboratory, Inc., to collect this sample for me or the person named above for whom I am the legal guardian. I hereby release The PMH Laboratory, Inc. its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, venous blood draw or the administration of same including, but not limited to, acts of negligence. I have voluntarily requested this venous blood draw outside the course and scope of my employment. The PMH Laboratory, Inc., will use and disclose your personal and health information to treat you, to receive payment for the care we provide, to public health agencies as required, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regard to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 5 minutes after collection of samples. This test is for informational purposes only and to be discussed with your health care professional. The PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any outcome in your care or treatment.

PATIENT NAME (*Please print*): _____

PATIENT SIGNATURE: _____

DATE: _____