

**INFORMED CONSENT FOR MAMMOGRAMS AND BLOOD TESTS**

**YOUR LAB WORK AND/OR MAMMOGRAM MAY OR MAY NOT BE COVERED BY YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR DETERMINING INSURANCE COVERAGE FOR THESE TESTS AND ANY PAYMENTS TO OUTSIDE LABORATORIES AND FACILITIES WHICH PERFORM TESTS FOR YOU.**

Please read the following tests below. Check the group of tests that you would like to have drawn during your visit or you can circle the individual test(s) if you do not want the group of tests performed.

\_\_\_\_\_ **Screening Blood Work** (Comprehensive Metabolic Panel, Complete Blood Count, Lipid Panel, Thyroid Panel)

\_\_\_\_\_ **Sexually Transmitted Diseases** (Blood Work: Hepatitis Panel (A, B, C), RPR (Syphilis), Herpes Simplex I & II) (Cervical Testing: Gonorrhea, Chlamydia)

\_\_\_\_\_ **HIV-1 Antibody** (I understand that the performance and results of the HIV antibody test are considered confidential. I understand that the test results in my health record shall not be released without my expressed written permission except to the individuals and organizations that have been given access by law, who also are required to keep my health information confidential. These include me, my physician, health care facility staff who provide my health care or handle specimens of my body fluids or tissues, funeral directors, court of record under lawful order and the Health and Human Services Department/Travis County Health Department as required by law.)

\_\_\_\_\_ **Annual Mammogram** (Baseline for patients age 35-39, age 40 and over yearly, as needed for family history of abnormal)

\_\_\_\_\_ **Bone Density** (Recommended usually every 24 months once menopausal or at risk for bone loss)

\_\_\_\_\_ **Other** (List any other tests/procedures you would like to have done on the line below)

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**\*\*\*Please note: It is our policy for the PAP test to be performed with HPV typing in order to enhance the detection of cervical dysplasia/cancer in patients 30 years of age and above. If you have questions on HPV testing please discuss with the nurse or provider during your visit.**

I have read the information above and understand its content. I understand that I may ask questions at any time regarding the tests above. I hereby give my consent to have my blood drawn for the following lab(s) listed above that I have checked/circled.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_