TAHOE FOREST HEALTH SYSTEM

Community Health Screenings

Thank you for choosing Tahoe Forest Health System. If you have questions about the results of these tests, please contact your health care provider. If you do not have one, we are happy to make available a list of providers within our health system.

Today's Date		**Date of Birth**	
Patient Name			
Mailing Address			
Physical Address			
City, State, Zip			
Phone Number		**Email Address**	

Tests Available	**Selection**	**Price**
Complete Blood Count (w/o Differential) - CBC - (Lab 294)		$13
Comprehensive Metabolic Panel - CMP - (Lab 17) *12-hour fast is required. Take prescribed medications and drink water to avoid dehydration.*		$29
Lipid Panel - (**Lab18)** *12-hour fast is required. Take prescribed medications and drink water to avoid dehydration.*		$35
Vitamin D, 25 – Hydroxy - (Lab 535)		$44
Hemoglobin A1c (HgA1c) - (Lab 90)		$28
Thyroid-stimulating Hormone – TSH - (Lab 129)		$34
PSA – Prostate Antigen Screen – (Lab 116)		$87
Staff Notes		

As part of this community health screen the undersigned hereby requests that health screenings be performed by representatives of Tahoe Forest Health System.

I hereby release the above mentioned representatives from any and all liability, including any matter or thing committed or omitted which may arise during blood drawing or other screenings or from data derived there from. I understand that:

1) The data derived from such health screenings is to be considered as preliminary only and is in no way conclusive.
2) The responsibility for initiating any follow-up examination for abnormalities identified at the health screen lies with me as the person responsible for my own health and not with any participating representative.
3) Health screen staff will have access to my screening results for the sole purpose of determining if the results are out of normal limits and aiding me in initiating a follow-up exam. No other individual or agency will have access to my individual screening results without express written permission from me. Aggregate data may be used for report and research purposes.
4) **I understand that these labs are offered at a retail discounted price and fees must be paid in full at the time of service to qualify for this discounted rate. Although I may have insurance which may cover all or part of the services rendered today, by signing below I agree that I will not submit or ask Tahoe Forest Hospital District to submit an insurance claim on my behalf to any insurance plan for these services, otherwise this discount will be reversed and the normal lab fees will apply.**

Patient Signature:_____ **Date:** _____

For Office Use Only – Check one:

☐ Patient has lab orders in Epic; Ordering Provider: _____

☐ Patient does not have lab orders in Epic; Dr. Evans is the ordering provider.

Tahoe Forest Hospital District
Tahoe Forest Hospital
10121 Pine Avenue
Truckee, CA 96161
HIM Fax: 530-582-1864
HIM Email: HIMROI@tfhd.com

TAHOE FOREST HOSPITAL DISTRICT

Incline Village Community Hospital
Incline Village Community Hospital
880 Alder Avenue
Incline Village, NV 89451-8215

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone Number: _____ Email: _____

Information to be Released From:

❑ TFH ❑ IVCH Doctor's Name(s): _____

Purpose of Requested Use or Disclosure:

❑ Continuity of Care – Appointment Date with Physician: ___/___/_____

❑ Patient ❑ Insurance ❑ Other: _____

Person / Organization Authorized to Receive Information

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone Number: _____ Email: _____

Fax Number: _____

Health Information Requested (Check all that apply)

❑ Consultation Reports
❑ Discharge Summary
❑ Emergency Room Reports
❑ **All Medical Records**
❑ History and Physical
❑ Laboratory Tests
❑ Procedure Reports
❑ **Billing Records**
❑ Progress Notes
❑ Imaging Reports
❑ Images on USB
❑ Images Via The Cloud

❑ Date(s): _____

❑ Other: _____

Note: Records may include information related to mental health, alcohol/drug use, and HIV/AIDS. However, treatment records from mental health and/or alcohol/drug *departments* and/or *results of HIV tests* will not be disclosed unless specifically requested below.

❑ Mental Health Records ❑ Alcohol/Drug Records ❑ HIV Test Results Records

Distribution: White copy - HIM Department, Yellow copy - Customer copy

Method of Delivery of Requested Records

❑ Mail ❑ Pickup ❑ Encrypted Flash Drive

❑ Electronic Delivery Recipient Email: _____

Duration / Revocation / Redisclosure

- The authorization is effective for one year from the date of signature unless a different date is specified here: _____ (date).
- The authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.
- A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

Patient Signature*: _____

Date: _____

Print Name: _____

*If not signed by the patient, please indicate relationship to the patient (check one if applicable):

❑ Parent or guardian of minor patient who could not have consented to health care.

❑ Guardian or conservator of an incompetent patient.

❑ Beneficiary or personal representative of deceased patient.

There may be fees incurred for this service.

ROI Email Disclaimer:

Despite TFHD's best efforts there are inherent risks associated with the transmission of PHI particularly when communicated via email. While we utilize secure methods to transmit sensitive data, including secure encryption and other technological safeguards, it's important to recognize that no electronic communication method is entirely immune to potential breaches or exposure. By signing this disclosure, you acknowledge TFHD cannot guarantee absolute protection against unauthorized access or interception during transmission. You understand and accept the risks associated with the transmission of personal health information via email. Please note that a third party may manage and retain email information on our behalf, and they are required to adhere to HIPAA guidelines.