healthchek

Patient Registration - Please Print

Name: _____
Last First MI

☐ Male
☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____/_____/_____

Email: _____

(I authorize Healthchek to send me a monthly newsletter)

How would you like to get your test results ?

☐ **Mail** *(Usually received in 7-10 days)*

☐ **Fax to Doctor Name** _____

☐ **Fax #:** _____

Phone #: _____

Pick Up / I Authorize Name (another) _____

☐ **Email:** _____

HIPAA COMPLIANCE: Healthchek uses a secure and encrypted email service to send results.

Who referred us to you?

Authorization & Consent by signing below:

I authorize Healthchek to perform health testing as part of a wellness screening program, using Quest Diagnosic Laboratory analysis. Healthchek provides Quest Diagnostics with information, Healthchek shall not be held liable for any misuse, unauthorized access, or breaches of personally identifiable information (PII) by Quest Diagnostics. Quest Diagnostics acknowledges and agrees that it is solely responsible for the security, storage, processing, and use of PII provided by Healthchek. This includes adherence to all applicable laws and regulation, including HIPAA, HITECH, and other relevant data privacy standards.
I understand that in no way does Healthchek propose, diagnose, or recommend medical treatment.
I understand that it is my responsibility to contact my personal physician to follow through with these test results.
I relieve Healthchek and its employees from any liabilities relating to the confidentiality of my personal test results.
I authorize Healthchek to release my test results to any named recipients listed above.
I authorize Healthchek to send my test results using any of the methods of delivery I have identified above.
I authorize Healthchek to email me a monthly newsletter.

Signature: _____ **Date:** _____