

# ALERT Health, Inc. Consent Form

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  am  pm

Initial  
Here

**Consent for Testing and Treatment:** I consent to receive care at ALERT Health, Inc. This care includes, but is not limited to, laboratory tests, vaccination shots, and administration of medications as prescribed by the doctor.

Initial  
Here

**Consent for Phone Communications:** I consent to have ALERT Health staff contact me by phone to remind me about my appointments and/or to discuss my test results.

**Phone #:** ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**OK to leave a voice message?**  Yes  No

I grant permission to ALERT Health, Inc. to use my health information in summaries and reports, providing that my personal information (such as my name, address, birth-date and social security number) is removed.

I also understand that this consent form is valid and remains in effect as long as I receive care at ALERT Health, Inc.

I have read this form, or it has been explained to me, and I fully agree to its contents.

**Client Signature:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_