women's center for health

PATIENT'S BILLING CONSENT FOR HIV TESTING

please PRINT all information clearly

Women's Center for Health: ☐ Naperville ☐ Bolingbrook ☐ Plainfield

SELECT ONE OPTION BELOW

☐ I authorize the disclosure of my name, address, birth date, and the name and results of the test(s) to any person or corporation which is, or may be, liable under a contract to the hospital or to the patient or to an authorized agent or employer of the patient, for all or part of the hospital's charge, including, but not limited to, hospital or medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer.

☐ I DO NOT give my consent to release the name or results of the test(s) to any or all of the above mentioned persons or corporations. I understand that my refusal to give consent may result in the refusal of my insurance company to pay benefits for this hospitalization, and that I will be liable for payment of all or part of the hospital bill.

Patient's Name _____ Birthdate _____

Street _____ Apt. # _____

City _____ State _____ Zip Code _____

Signature of Patient or Legal Representative _____ Date _____

If Representative, state relationship to Patient _____

Signature of Witness _____ Date _____