



Patient Identification Label	
Name	_____
MRN	_____
DOB	_____
Date of service	_____

**Direct Access Testing Consent**

**Consent for Treatment/Payment/Receipt of Results**

This is to certify that I consent to and authorize Gunnison Valley Health/Gunnison Valley Hospital (collectively, "Hospital") to collect my blood and/or urine for analysis of the marked Direct Access Testing. Direct Access Testing ("DAT") is patient-initiated testing that does not require a physician's order. I authorize the Hospital to release my results to me through the method indicated on this form. In performing the patient-initiated testing, I understand that Hospital is not acting as my doctor, that this does not replace treatment by a physician and that I assume complete and full responsibility to take appropriate action regarding test results, up to and including consulting with a physician. In this regard, I do not and will not hold the Hospital responsible for my test results and absolve them and their affiliates of any liability. **I agree that I will seek medical advice, care, and treatment from my usual source of health care if I have questions or concerns, have any symptoms of illness, or become ill.** I understand that the venipuncture process involves a small medical risk and may result in bruising around the area from which the blood is taken. In the event of an accidental needle puncture to Hospital's staff member involved in the blood collection process, I consent to any routine blood test deemed necessary for the safety of the phlebotomist. As with laboratory testing of any nature, the potential for falsely elevated, lowered, positive or negative laboratory values is present.

I agree to take full fiscal responsibility for the tests requested, and I understand that payment is required prior to specimen collection. I understand that the DAT I am requesting on the attached form will not be billed to a third party by Hospital and that my results will not be sent to a physician or health care provider, though the results will be available for review in my medical record and patient portal. Certain Providers may be able to access results electronically via QHN.

I understand the cost of DAT may increase in the future without prior notice. I understand that medical insurance does not usually cover the cost of DAT and usually will not reimburse these charges or apply them towards a deductible when they are not ordered by a physician. I accept full responsibility for inquiring with my insurer in this regard.

Please select the method you prefer to receive your results:

- Access results via Patient Portal
- Fill out a Medical Records Request form (970) 641-7257 or email to: [mr@gvh-colorado.org](mailto:mr@gvh-colorado.org)

\_\_\_\_\_  
Name of patient (printed)

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Signature of patient or legally authorized representative (if under the age of 18)

\_\_\_\_\_  
Phone number for emergent/critical lab results

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date Time



Name \_\_\_\_\_  
 MRN \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Date of service \_\_\_\_\_

**Available Tests and Pricing**

	Test Description	CPT	Price	Instructions
<input type="checkbox"/>	ABO	86900	\$38	
<input type="checkbox"/>	ABO Rh	86900, 86901	\$60	
<input type="checkbox"/>	CBC w/o manual differential – Complete Blood Count	85025	\$30	
<input type="checkbox"/>	CMP – Comprehensive metabolic Panel	80053	\$43	
<input type="checkbox"/>	CRP – C- Reactive Protein	86140	\$25	
<input type="checkbox"/>	Estradiol	82670	\$64	
<input type="checkbox"/>	Ferritin	82728	\$42	
<input type="checkbox"/>	Folate	82746	\$44	Fasting required
<input type="checkbox"/>	FSH – Follicle Stimulating Hormone	83001	\$55	
<input type="checkbox"/>	Free T3	84481	\$55	
<input type="checkbox"/>	Free T4	88839	\$40	
<input type="checkbox"/>	Hepatitis C Ab	86803	\$45	
<input type="checkbox"/>	HGB A1C	83036	\$38	
<input type="checkbox"/>	Iron	83540	\$31	
<input type="checkbox"/>	Iron and TIBC	83540, 83550	\$57	
<input type="checkbox"/>	LDL- Low-density Lipoprotein	83721	\$27	Fasting required
<input type="checkbox"/>	Lipid Panel (Cholesterol, Triglyceride, High-density Lipoprotein)	80061	\$39	Fasting required
<input type="checkbox"/>	Magnesium	83735	\$28	
<input type="checkbox"/>	Pregnancy, serum	84703	\$20	
<input type="checkbox"/>	Pregnancy, urine	84703	\$20	
<input type="checkbox"/>	Progesterone	84144	\$45	
<input type="checkbox"/>	Rh	86901	\$22	
<input type="checkbox"/>	Testosterone, Total, Bioavailable and Free	84402, 84403, 84410	\$80	
<input type="checkbox"/>	Testosterone, Free and Total	84402, 84403	\$65	
<input type="checkbox"/>	Thyroxine Antibodies	86376	\$40	
<input type="checkbox"/>	TSH – Thyroid Stimulating Hormone	84443	\$39	
<input type="checkbox"/>	Urinalysis w/out microscopic	81001	\$25	
<input type="checkbox"/>	Vitamin B-12	82607	\$43	
<input type="checkbox"/>	Vitamin D – 25-Hydroxy Vitamin D	82306	\$58	