WELLNESS SCREENING RESULTS DELIVERY FORM

v1.0

Please complete this form to indicate how you would like to receive your wellness screening results.

Patient Information

Full Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: (_____) _____ - _____

Email Address: _____

Preferred Method of Receiving Results
(Please check one option below)

☐ **Email**
Please send my results to the following email address:
Email: _____

☐ **Mail**
Please mail my results to the following address:
Street Address: _____
City: _____ State: _____ Zip: _____

☐ **In-Person Pickup**
I will pick up my results in person.
Note: I understand that I must schedule a pickup time with the receptionist on the date of service.

Optional: Send Summary to Your Doctor
Would you like us to send a copy of your wellness screening summary to your doctor of choice?
(Please check one)

☐ Yes ☐ No

If yes, please complete the following:

Doctor's Name: _____

Clinic / Practice Name: _____

Email Address: _____

Phone Number: (_____) _____ - _____

Patient Authorization

By signing below, I authorize Virginia Beach Diagnostics to release my wellness screening results by the method selected above. I understand that email is not a guaranteed secure method of transmission unless otherwise encrypted, and I accept the risks associated with this choice. I also authorize Virginia Beach Diagnostics to share my summary with the listed physician if I have indicated "Yes" above.

Signature: _____

Date: ____ / ____ / _____