ETERNAL BEAUTY LIFESTYLE
BLOOD WORK & LABORATORY TESTING CONSENT

Patient Name: _____

Date of Birth: _____

Date: _____

PURPOSE OF LABORATORY TESTING

I understand that my healthcare provider may recommend blood work and/or other laboratory testing as part of my medical evaluation, treatment, monitoring, or wellness care. Laboratory testing may be used to assess general health, hormone levels, metabolic function, nutritional status, medication safety, treatment response, or other clinically relevant conditions.

I understand that the specific laboratory tests ordered will depend on my individual medical history, symptoms, medications, treatment goals, and clinical needs.

CONSENT TO BLOOD COLLECTION

I voluntarily consent to the collection of blood and/or other specimens necessary to perform the laboratory testing recommended by my healthcare provider.

I understand that blood collection is generally a routine procedure but may cause temporary discomfort. Possible risks include pain or tenderness, bruising, minor bleeding, swelling, lightheadedness, dizziness, fainting, infection, and rarely nerve irritation or injury.

I agree to inform the healthcare provider or laboratory personnel if I have a history of fainting with blood draws, bleeding disorders, difficulty with blood collection, or any other concern that may affect the procedure.

LABORATORY RESULTS

I understand that laboratory results may be normal, abnormal, inconclusive, or outside the expected reference range. Laboratory results must be interpreted in the context of my medical history, medications, symptoms, physical examination, and other clinical information.

I understand that an abnormal laboratory result does not necessarily mean that I have a medical condition, and a normal result does not necessarily rule out a medical condition.

Additional testing, repeat testing, referral, or medical evaluation may be recommended when clinically appropriate.

TEST PREPARATION

I understand that certain laboratory tests may require specific preparation, including fasting, timing of medications or supplements, timing in relation to hormone therapy, or timing within my menstrual cycle.

I agree to follow any preparation instructions provided to me and understand that failure to follow preparation instructions may affect the accuracy or interpretation of my results.

PRIVACY AND RELEASE OF RESULTS

I understand that my laboratory results constitute protected health information and will be handled in accordance with applicable privacy laws and regulations.

I authorize Eternal Beauty Lifestyle and its healthcare providers to receive, review, document, and discuss my laboratory results as necessary for my care.

LIMITATIONS OF LABORATORY TESTING

I understand that no laboratory test is perfect and that false-positive or false-negative results can occur.

I understand that laboratory testing is only one component of medical decision-making and that my provider may recommend additional evaluation or testing based on my results and overall clinical presentation.

PATIENT ACKNOWLEDGMENT AND CONSENT

By signing below, I confirm that:

□ I have read and understand this consent form.

□ I have had the opportunity to ask questions regarding the recommended laboratory testing.

□ My questions have been answered to my satisfaction.

□ I understand the potential risks associated with blood collection.

□ I understand that laboratory results may require additional evaluation or testing.

□ I have provided accurate and complete information to the best of my knowledge.

□ I voluntarily consent to the recommended blood work and laboratory testing.

Patient Signature: _____

Date: _____

Provider/Clinician Name: _____

Provider Signature: _____

Date: _____

Eternal Beauty Lifestyle
Clearwater, Florida