# Community Health Services of Union County, Inc.
## Diabetes Education Health Screening Form

**Name:** ______________________________________________________ **Date of Birth** ___________________

**Mailing Address:** ______________________________________________________ **Zip Code:** _____________

**Phone: (H)**___________________________ **(W)**_________________________ **Gender:**____**Male** ____**Female**

**Employer Name:** ______________________ **Retired** ___ **Unemployed** ___ **Disabled** ___ **Number in household:** _____

**Race:** ☐**Asian** ☐ **Black/Afr. Amer.** ☐ **Hispanic/Latino** ☐ **Multi-Racial** ☐ **Native American** ☐ **White** ☐**Other**

**Income:** ☐ $0 to $9,999 ☐ $25,000 to $34,999 ☐ $75,000 to $99,999 ☐ $150,000 to $199,999

☐ $10,000 to $14,999 ☐ $35,000 to $49,999 ☐ $100,000 to 149,999 ☐ $200,000 or more

☐ $15,000 to $24,999 ☐ $50,000 to $74,999

**Health Insurance Coverage (please check all that apply)** ☐ **Medicare** ☐ **Medicare Supplement**

☐ **Medicaid** ☐ **Private Insurance** ☐ **NC Health Choice** ☐ **None**

**Consent and Release for Drawing of a Blood Sample**

**I consent to the drawing of a blood sample for requested blood work. I release Community Health Services and any other organization(s) associated with this screening from any and all liability. I understand that:**

**(1) This test is for screening purposes only and a diagnosis cannot be made from it.**
**(2) The CHS nurse will discuss the results with me.**
**(3) My results are confidential and will not be given to anyone without my written permission.**

**Signature:**_______________________________________________________ **Date** _____/_____/_____

**Initial**______ **Date** ___/___/___ **Initial**______ **Date** ___/___/___ **Initial**______ **Date** ___/___/___ **Initial**______ **Date** ___/___/___
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## AUTHORIZATION FOR COMMUNITY HEALTH SERVICES TO RELEASE INFORMATION

**TO WHOM IT MAY CONCERN:**

**This is to authorize Community Health Services, its affiliates, agents, and employees to release any and all records, documents, information, or opinions which may be requested regarding my medical and/or financial condition to any person, firm, agency, or organization as to which such information appears to Community Health Services to be reasonable or necessary to enable myself and/or my family to obtain medical, financial, and/or rehabilitative assistance.**

**Signature**_______________________________________ **Date**_________________