Consent and Release Statement

By signing below I hereby request a health screening test(s) to be performed by St. Mary's Medical Center. I am voluntarily participating in the health screening event and therefore release St Mary's Medical Center, its employees and agents from any and all liability; including any injury and damage to me arising out of my participation in the health screening.

It is further understood that:

1. The data delivered from such screening/tests is to be considered preliminary only and in no way conclusive.
2. The responsibility for initiating any follow-up examination for abnormalities identified lies with my personal physician and not with St Mary's Medical Center.
3. I give permission for health volunteers to have access to my results for the purpose of ascertaining if the results are abnormal and aiding me in initiating a referral for follow-up purposes.
4. It is my responsibility to make any physicians aware of the results of my health screening/test(s) and I understand and agree that such responsibility in no way lies with St Mary's Medical Center.

Please Print

Name:_____Date of Birth:_____

Phone:_____ Personal Physician:_____

Address:_____

_____

Sex: (circle one) Male Female

Wellness Profile - $25

Optional testing: (circle one/multiple) TSH - $5 HbA1C - $5 Vitamin D - $15 PSA - $15

Signature:_____

Witness Signature:_____

For lab use only

Performed at:_____

Total amount collected:_____ Check:_____ Cash: _____ Credit:_____