Health Screen Consent and Release of Liability Statement

Valley County Health System
Progressive Care with Compassion

TESTS REQUESTED

☐ **Health Screen:** **$35.00**
- Comprehensive Metabolic Panel: Kidney & Liver Function, Electrolytes
- Complete Blood Count
- Thyroid: TSH
- Cholesterol & Triglycerides

☐ **PSA:** Prostate cancer screening - recommended for males over age 50 **$15.00**

☐ **A1C:** Measures average blood sugar for past 2 – 3 months **$20.00**

☐ **Protime:** For patients on Warfarin **$10.00**

Total $_____
Cash/Check/Credit

I hereby authorize Valley County Health System (the "Hospital"), or its designee, to perform a Health Screen/PSA **(circle one or both as applicable)** on me and consent to allow the collection of a blood sample from me for the purpose of performing said testing.

I understand and acknowledge that undergoing a blood draw and receiving these screening services does not make me a patient of the Hospital.

I have been advised that these tests are not intended to replace any testing or evaluations which could be performed by my personal physician and are not intended to replace the ongoing care of my personal physician.

I understand and acknowledge that the screening results will be reported by the Hospital to me alone and will not be provided to my physician or any other third parties. The Hospital does not and will not review or retain any records related to these tests. These results will not be included in or become a part of any medical record maintained by the Hospital.

I understand and acknowledge that the purpose of this testing is limited to an initial screen, and I agree that I am solely responsible for any follow-up care or testing with my physician as a result of these tests. If follow-up care is desired, it is my responsibility to take the results of these screening tests to my physician as the results will not be made available to my physician by the Hospital.

I HEREBY RELEASE THE HOSPITAL, HEALTH FAIR SPONSORS. CONTRIBUTING ORGANIZATIONS AND THE PERFORMING LABORATORY FROM ANY AND ALL LIABILITY RELATED TO AND OR ARISING FROM ANY ACT OR OMISSION WHICH MAY OCCUR DURING THE BLOOD DRAW OR FROM THE DATA AND RESULTS DERIVED THEREFROM.

By my signature below, I certify that: (i) I have fully read and understood this consent form; (ii) I have been given the opportunity to ask questions about these screening procedures and the risks and hazards involved, and all the questions I asked were answered in a satisfactory manner and in terms in which I understood; and (iii) I request and agree to have the Health Screen/PSA performed and blood sample collected as set forth above.

_____ Male☐ Female☐ Date of Birth: _____
Full Name (Please print)

_____ _____ _____
Signature – Patient/Legally Authorized Representative Date Phone

_____
Relationship to Patient if Legally Authorized Representative

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www.ValleyCountyHealthSystem.org

June 2024

To: Valley County Health System Health Fair Participants

Re: Screening Test Consent and Release Statement

In signing this consent form to allow the drawing of blood and to permit the testing that is requested, I have been advised that all of the procedures in this screening are not intended to replace any testing or evaluations which could be accomplished by my personal physician.

It is understood that the screening results which will be reported to me are for my use only and that these results will not be included in the hospital's records. It is my responsibility to determine if I would like to schedule any follow-up medical care as a result of this screening. No other individual or agency, including my personal physician, will have access to my individual test results.

Because the test has not been ordered by my physician, I understand it is not possible for questions regarding the results of the test to be answered by a phone call to my physician. If follow-up care is desired, it is my responsibility to schedule a visit with my personal physician and to take the results this test to my physician as these records will not be made available to my physician.

It may be necessary for these screening tests to be repeated or additional testing to be done as a result of my physician's clinical judgment, and I will discuss these options with my physician during our personal visit.

I understand that by signing the consent form, I am releasing Valley County Health System, health fair sponsors, contributing organizations and the performing laboratory from any and all liability related to or arising out of the blood draw or from the data and results derived therefrom.

PARTICIPANT'S COPY

Please retain for your records.

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