HAMILTON COUNTY

MINORITY HEALTH FAIR

CONSENT AND RELEASE FORM

Name:_____ Email: _____

Address:_____

City:_____ State:_____ Zip:_____

Telephone: _____ Gender:_____ DOB:_____

Primary Care Physician:_____ Phone:_____

I consent to the drawing of blood, performance of an electrocardiogram and the performance of other screening tests during the "Hamilton County Minority Health Fair." I release Eastgate Town Center, CHI Memorial, Chattanooga College, Kappa Alpha Psi Fraternity, Inc., Omega Psi Phi Fraternity, Inc., Delta Sigma Theta Sorority, Inc., the Southeast Tennessee Health Consortium, participating physicians, other sponsors or health care providers of this event from any and all liability related to the performance of these and other tests, or the data that results from the analysis of this testing and other medical screening activity. I also hereby understand and agree that photographs and data collected from this event may be used for research and publicity for future health fairs. I also hereby understand and agree that:

1. The studies done today are for the purpose of screening and do not constitute a complete diagnostic examination or a therapy session.
2. The studies done today are voluntary and free of charge.
3. The findings will be reported to me with the recommendations for follow-up care if indicated. The responsibility for follow-up to confirm the results of the screening are mine alone and not that of any other person, firm, corporation, fraternity or other entity.
4. No guarantee of any kind is made to me with respect to these screening tests.
5. The findings are preliminary and are not to be considered conclusive.
6. Even if I follow completely the advice given to me in this screening, there is no assurance that I will not suffer from a disease, cancer and/or other serious health condition.
7. The information I provide during the screening and the actual test results will remain confidential.
8. A copy of my lab test results will be sent to me and if results are abnormal, an explanation will be provided to my physician if requested.

	Yes	No
Do you smoke?	☐	☐
Do you have diabetes?	☐	☐
Do you have high blood pressure?	☐	☐

I would like to receive notification and communications about healthcare education, healthcare benefits and services from the Southeast Tennessee Health Consortium Foundation and Simple Choice Marketing Group, Inc.

☐ Opt-In

☐ Opt-Out

Attendee Signature: _____ ***Date:*** _____