Appalachian Regional Healthcare System

COMMUNITY HEALTH SCREENING CONSENT AGREEMENT

The undersigned hereby requests that a health screening be performed by the Appalachian Regional Healthcare System, Inc.'s (herein after referred to as "ARHS" or "Sponsor") staff present at the Community Health Screening on _____ at _____.

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING: The data derived from the screening is to be considered as preliminary only and in no way conclusive. The screenings are not diagnostic and may occasionally miss abnormalities which more definitive tests would detect. The professionals involved do not have access to and cannot consider my past medical history or certain characteristics of my overall health. I recognize that the screenings I receive may be provided by physicians, nurses, physical therapists or other professionals who are independent contractors not employed by ARHS. The Sponsor does not endorse or guarantee the results of such tests and may have no control over individuals providing this service. No physician-patient relationship will be formed by participation in this Community Health Screening and no patient medical record will be created or maintained.

It is my choice if I wish to obtain any follow-up evaluation or care concerning any and all results detected at this health screening. I am solely responsible for obtaining appropriate medical attention and advice, if any, and may contact any health provider I wish. Neither the Sponsor nor any individual involved in the health screening is responsible for any necessary continuing care. **I understand and acknowledge that there is a minor risk of injury or harm due to the tests I am voluntarily requesting be performed and I agree to assume such risk. Furthermore, at any time during the screening, if I do not wish to continue, I may withdraw from the screening process.**

Privacy Standards:
In the screening environment, because of the space limitations, there can be no guarantee that everything said during the actual screening event will be confidential. Those clients being served in surrounding stations may be able to overhear information about you, i.e., your screening results. If there is information being asked or being discussed about which you do not feel comfortable, you may ask any of our staff to speak with you "one-on-one" in another area. I understand that by signing this form I am agreeing to allow the ARHS Community Health Department staff to assess me in the screening, and discuss the immediate results, data and healthcare information needed for record keeping, along with answering any questions that I may have. I understand that other participants may overhear what is being said. I am waiving, or giving up my right to privacy of healthcare information, only during the screening event.

I understand that if I have concerns about divulging information, I may request any staff member to meet and discuss healthcare information in a more private location. I acknowledge that I have had an opportunity to read and review ARHS's Notice of Privacy and to receive a copy of the same. If you have any questions contact ARHS Community Outreach at 828-268-8960 or cfjones@apprhs.org.

I AM EIGHTEEN (18) YEARS OF AGE OR OLDER, COMPETENT, HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND DESIRE TO HAVE SUCH SCREENING PURSUANT TO THE TERMS CONTAINED HEREIN. I HEREBY RELEASE AND FOREVER DISCHARGE ARHS, ITS' RESPECTIVE AFFILIATES, OFFICERS, DIRECTORS, EMPLOYEES, VOLUNTEERS, AND AGENTS FROM ANY AND ALL LIABILITY, CAUSES OF ACTIONS, SUITS, CLAIMS AND DEMANDS OF ANY KIND WHATSOEVER ARISING FROM OR IN ANY WAY CONNECTED WITH THE PHYSICAL ACTIVITY, OR OTHER PROCEDURES NECESSARY TO CONDUCT THIS SCREENING. MY SIGNATURE BELOW INDICATES MY CONSENT TO PARTICIPATE IN THIS SCREENING.

Print Name/ DOB	**Sign Name**