Free Health Screening Clinic/Health Fair

Registration Form

The following information is required for health screening purposes only. Should you need a more extensive medical check-up, please ask the physician(s) examining you and you will be directed accordingly.

____
Last Name First Name Middle Initial

____
Male/Female Date of Birth (Month/Day/Year) Home Phone Number Cellular Phone Number

____
Address City State ZIP

DISCLOSURE: I am under a Physician's care and/or seeing a Health Professional and/or seeing a Psychologist, Psychiatrist or Counselor: ___Yes ___ No. If you indicated "Yes", please note name, address, and phone # of the Health Professional.

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Consent to Health Screening, Photograph Release and Waiver of Liability

I understand, acknowledge, and agree to the following:

1. I am voluntarily participating in the Free Health Screening Clinic/Health Fair. I understand that any screening is limited in nature and not a substitute for seeking medical treatment or follow up with a health care provider. I understand that it is my responsibility to follow up on any recommendations that made to me during any screening at the Health Clinic/Fair and to obtain follow up testing, diagnosis and advice from a health care provider of my choosing.
2. This Health Screening is being conducted by volunteer physicians, dentists, pharmacists and other health care professionals/assistants ("Volunteers") for my best interests and is preliminary in nature only and is provided free of cost.
3. Community Health Centers of Pinellas, Inc. (CHCP), its officers, members and the participating health care volunteers make no claims, representations nor guarantees with respect to the accuracy or precision of evaluation(s) due to the limited nature of the service provided.
4. I understand that any screening results concerning me are confidential and shall not be release without my consent unless required by law. I acknowledge that I have been provided with the opportunity to receive a copy of CHCP's Notice of Privacy Practice which further explains my privacy rights.
5. In exchange for the screening services being provided, I agree to release, discharge, and hold harmless all entities and individuals providing screening services as a part of the Health Clinic/Fair including, but not limited to CHCP, its directors, officers, employees and agents, from any and all claims, demands, losses, damages, or injuries, arising from, or based in whole or in part on my participation in the Health Clinic/Fair.
6. I understand that the activities of this Health Clinic/Health Fair may be filmed or photographed, and such films or photographs may contain my picture or likeness. I further understand that such films or photographs may be used for various purposes including films and publications for non-commercial and/or commercial purposes. I expressly waive my rights of privacy and physician/patient privilege and authorize the filming or photographing of my person or likeness for usage including but not limited to films, published articles for commercial as well as non-commercial purposes.
7. I UNDERSTAND THAT MY SEEKING THE ADVICE OF PHYSICIANS AT THIS HEALTH FAIR DOES NOT CREATE A PHYSICIAN/PATIENT RELATIONSHIP BETWEEN MYSELF AND ANY PHYSICIAN OR HEALTH CARE PROVIDER AT THIS FAIR.
8. I acknowledge that I have read this Waiver, or have had it read to me, I have understood the provisions, or have had it explained to me, and my waiver is made knowingly, voluntarily and intelligently.

Signature of Patient/Guardian ___________________________ Signature of Witness _______________________________

Name of Patient _____________________________________ Name of Witness__________________________________

Date ____ Date____