

FAIR LAWN HEALTH DEPARTMENT BLOOD SCREENING & PSA CONSENT FORM

Provider: Medical Laboratory Diagnostics

Patient's Name: _____
(Please print)

Address: _____
(Street) (Town) (Zip code)

Tel No: _____ DOB _____ Age _____ Sex _____

Physician's Name: _____

Address: _____ Tel No: _____

I hereby certify that I have voluntarily applied for the above screening. I understand that this program is part of an early detection screening program and that it does not replace a complete annual examination by a doctor.

The undersigned acknowledges that the Borough of Fair Lawn has no control over any of the actions of the personnel associated with the screening, including but not limited to any treatment or procedure, examination, and/or testing performed by them.

The undersigned also acknowledges that the Borough of Fair Lawn is not liable for the improper administration or processing of any test or medical procedures, the accuracy of the results or any interpretation of such test or any medical treatment prescribed as a result of these tests or related procedures associated with the screening.

I hereby release the technicians, program personnel, and the Fair Lawn Health Department from any and all claims that I now have, or I may have, against them as a result of this screening. I, the undersigned, do hereby authorize the furnishings of a report of the findings of this screening to my family physician, as indicated above.

Blood test to be performed: Blood Screen/T4 Blood Screen/PSA T4 PSA
(Circle all that apply)

Signature _____ Date _____

Payment by: Check made payable to: **Borough of Fair Lawn**

Check #: _____ or cash amt _____ rec'd by _____