



## Health Fair Screening Consent

I, \_\_\_\_\_, hereby consent to participate in the health fair screening organized by DHHS MOBILE HEALTH CLINIC. I understand that this screening aims to provide me with important health information and recommendations based on the results.

I acknowledge the following:

1. **Purpose:** The purpose of the health fair screening is to identify potential health risks and provide education and resources to promote well-being.
2. **Confidentiality:** The information collected during the screening will be kept confidential and will only be shared with necessary healthcare professionals and staff involved in the event. Our Notice of Privacy Practices (NOPP) tells you:
  1. How we will use your information
  2. How we will disclose your information.
  3. How to request copies of your information
  4. How to contact the Department's Privacy Officer
3. **Voluntary Participation:** My participation in the health fair screening is voluntary, and I understand that I have the right to refuse or discontinue any specific test or procedure at any time.
4. **Informed Decisions:** I have received adequate information about the screening procedures, tests, and potential risks or benefits. I have had the opportunity to ask questions, and my concerns have been addressed satisfactorily.
5. **Results and Recommendations:** I understand that the screening may provide me with results and recommendations based on the data collected. These results are intended for informational purposes only and should not replace a comprehensive medical evaluation by a qualified healthcare provider.
6. **Follow-up Care:** If further evaluation or treatment is recommended based on the screening results, it is my responsibility to seek appropriate healthcare services.
7. **Limitations:** I understand that the health fair screening has its limitations and may not detect all possible health conditions or risks.
8. **Media Release:** I hereby grant permission to DHHS MOBILE HEALTH CLINIC to use any photographs or videos taken during the health fair screening for promotional, educational, or fundraising purposes.

Please provide with your initials here if you agree to media release: \_\_\_\_\_

If you do not agree please leave blank. Thank you.

By signing this consent form, I acknowledge that I have read and understood all the information provided and agree to participate in the health fair screening voluntarily.

Signature

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_