

## Client Consent

I understand that:

1. The information obtained from these screenings is preliminary only and in no way conclusive.
2. The screenings are not diagnostic. Only a health professional can provide a diagnosis.
3. Not all screenings will be conducted by doctors and nurses.
4. I understand and hereby consent that these results will be shared with a Care Manager and/or with health care professionals who may contact me in an effort to provide me with further care.

**[IF AGENCY IS HIPAA REGULATED, THEN THE FOLLOWING WILL APPLY]**

5. Information from this screening is considered confidential to the full extent allowed under the law as per HIPAA requirements. Exceptions include cases of possible abuse or neglect (to a child, the elderly, or the incompetent), or imminent harm to either yourself (suicide, etc.) or another individual (violence, etc.). It is important that you know that we are mandated reporters and the law requires that confidentiality be waived if it is determined that you are a danger to yourself or others.
6. I understand that it is my sole responsibility to follow through on any and all potential abnormal health issues detected by obtaining appropriate medical attention and advice.

I release **(NAME OF ORGANIZATION)** from any and all liability that may arise from the screenings and/or information obtained from them, and/or from any information distributed. I have read and understand the above Consent and Release Agreement and desire to have such screenings pursuant to the terms contained herein.

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**Signature**

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**Date**