Advanced Diagnostics, Inc.

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Office (803)419-4235 Fax (803)419-4236

PATIENT INFORMATION			
Last Name:		**First Name:**	**Middle Initial:**
Date of Birth:	**Age:**	**School:**	**Sex:**
Mailing Address:		**City, State:**	**Zip Code:**
Primary Phone: ( )		**Email address:**	

EMERGENCY CONTACT		
Name:	**Phone#:**	**Relation to patient:**

ECHOCARDIOGRAM SCREENING

Do you have any heart conditions you are aware of? _____

I understand that Advanced Diagnostics, Inc. is providing an echocardiogram screening and I support Advanced Diagnostics' mission to identify unknown disease related to echocardiography.

I understand that this screening is NOT diagnostic in nature but is intended to identify those at risk for Abnormal Heart Function. I realize that I am responsible for reporting any findings from this screening to my physician, and if any condition exists that is not detected, I release Advanced Diagnostics, Inc. and all parties associated with this screening program from any and all liability concerning these tests. I also understand that it may not be possible to adequately evaluate all aspects of the heart due to body habitus limitations.

I understand that screening tests DO NOT replace examinations by my physician and even if my screening results are normal, there may be other conditions that are not detected and that I should have regular evaluations by my physician.

I have signed this release knowingly and voluntarily.

I hereby consent Advanced Diagnostics, Inc. to perform the screening of which I understand the above information. I hereby consent Advanced Diagnostics, Inc. to release my results to the email address listed above.

_____ _____

Signature of Guardian (unless student is 18 yrs and older) **Date**