McLaren Karmanos CANCER INSTITUTE

COLORECTAL CANCER SCREENING CONSENT FORM

Please Note: This form *must* be completed, signed, and returned with kit for test to be processed

Name _____ Date _____

Address _____
City State Zip

Phone Number _____ Date of Birth _____

Email _____ Sex M F Race _____

Do you have health insurance? Y N

Would you like your name and address added to our mailing list? Y N

If yes, do you prefer to receive this information via email or postal mail? _____

How did you hear about this screening? _____

Primary Care Physician Name: _____

Primary Care Physician Address: _____

I agree to voluntarily participate in the McLaren Colorectal Cancer Early Detection and Education Program. I understand this program will only screen for blood in the stool specimen provided and does not constitute a complete medical exam or diagnosis. I also understand that no screening or test is completely accurate in the detection of disease. For a diagnosis of a medical problem, I must see a physician/healthcare provider for a complete medical exam. If I do not have a personal physician, a list will be provided to me upon request.

I hereby release McLaren, Karmanos Cancer Institute, their employees, agents, volunteers and any other persons or organizations involved in this program from any claims or liabilities or expenses arising from my participation in these screening services or subsequent care, as well as any injury sustained in this event.

Release of Medical Information:
I understand that the results of this screening exam will be released to me and the confidentiality of the data will be maintained within legal limits. This information may be used in the future for statistical evaluation and scientific literature; however, I will not be individually identified in any recognizable way. I also allow the staff of McLaren, Karmanos Cancer Institute or its hospital affiliates to contact me at a later date to obtain follow-up information regarding this screening exam.

Signature: _____ Date: _____