Cardiology Risk Screening

CONSENT & RELEASE FORM

The undersigned gives his/her consent for the administration of an echocardiogram if the Cardiology Risk Screening indicates one is needed.

Further, the undersigned on his/her or their own behalf hereby release and discharge Memorial Hospital of South Bend, Inc., Memorial Health System, Inc. and their subsidiaries, affiliates, employees and directors from all liability, claims, actions or causes of action arising from or related to this cardiology risk screening, including the administration of an echocardiogram.

Your Name (print): _____

Signature: _____

Your Age: _____

Parent or Guardian: _____

Print Name: _____

Best time to reach you: _____

Best number to reach you: _____

Remember you are solely responsible for arranging any follow-up care which is indicated by your evaluation.

Memorial Medical Group℠
Advanced Cardiovascular Institute

574-647-1669

Memorial
SPORTS MEDICINE INSTITUTE℠

574-647-8120