18 Titus Road, PO Box 1272
Washington, CT 06793
(888) 852-2723
(888) 952-2723

MINOR CONSENT AND RELEASE FORM FOR LABORATORY HEALTH SCREENING

I, _____, _____ (relationship), hereby voluntarily consent to the following Laboratory Health Screening Test(s)

1._____

2._____

3._____

to be performed on the following minor child, which may include the drawing of blood, as has been recommended by
_____, the NON-LICENSED health care provider of record.
Full Name (Minor Child) _____ (hereafter "dependent")
DOB: ____/_____/_____(dd/mm/yyyy); Age: _____(Age at time of specimen collection)

I ACKNOWLEDGE AND UNDERSTAND THAT THE ABOVE LABORATORY HEALTH SCREENING TESTS MUST BE ORDERED BY A LICENSED HEALTH CARE PROVIDER, AND THAT EVEXIA DIAGNOSTICS, INC. WILL BE EMPLOYING A LICENSED HEALTH CARE PROVIDER FROM OUR EVEXIA INTERNAL PHYSICIAN NETWORK (EIPN) TO ORDER THESE TESTS. THE EIPN LICENSED PHYSICIAN WILL NOT BE RESPONSIBLE IN ANY WAY FOR THE RESULTS OF THE ABOVE LABORATORY TEST(S). THE EIPN LICENSED PHYSICIAN IS SIMPLY FACILITATING THE ORDERING OF THE LABORATORY HEALTH SCREENING TEST(S) RECOMMENDED BY THE ABOVE NON-LICENSED HEALTH CARE PROVIDER.

1.Explanation of the Laboratory Screening Test(s) and Associated Risks. This Laboratory Health Screening may include the taking of a small blood sample drawn by needle from your dependent's finger or arm. Your dependent could experience symptoms during this procedure such as abnormal blood pressure, fainting, irregular, fast or slow heart rhythm that may, in rare instances, lead to a serious health condition. You are strongly encouraged to ask questions of the screening staff if you do not understand the risks or the procedures to be performed.

2.Confidentiality and Use of Personal Information. By participating in this Laboratory Health Screening, you are granting permission to Evexia Diagnostics, Inc. (EDI) to use the information for emergency follow up if warranted, at the sole discretion of EDI. You may revoke this authorization of consent by providing written notice to EDI at any time by contacting EDI at **888-852-2723** or sending an email to **Support@EvexiaDiagnostics.com**. Any personally identifiable health information obtained in conjunction with this Laboratory Health Screening will be protected and will only be used in accordance with this consent agreement and applicable laws pertaining to the use of personal health information. Your dependent's information in aggregate form may be used for research, educational, or statistical purposes so long as the data does not personally identify you.

3.Responsibilities of the Participant. By choosing to participate in this Laboratory Health Screening, you certify that your dependent is in good health.

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4.Release of Claims. In consideration of your dependent's participation in this Laboratory Health Screening, you hereby agree to assume all risks of injury or death to your dependent. If your dependent has a disease condition, falls into certain high health risk categories, and/or receives abnormal laboratory test results, you should promptly consult with a physician and obtain his or her approval prior to engaging in any health improvement program or lifestyle change activity. EDI is not liable for any health consequences resulting from your dependent's participation in this program, and neither EDI nor its staff, including the **Evexia Internal Physician Network (EIPN)** physician who ordered the Laboratory Health Screening Test(s), is responsible for ensuring that you have consulted with your dependent's physician regarding any recommendations your dependent may receive as a result of your dependent's participation. Your dependent's test results will be automatically sent to your healthcare provider of record on your behalf. By your signature below, YOU HEREBY RELEASE EDI AND ALL OF ITS PERSONNEL AND AGENTS FROM ANY AND ALL DAMAGES AND CLAIMS CAUSED BY OR RESULTING FROM YOUR DEPENDENT'S PARTICIPATION IN THIS HEALTH SCREENING. *I acknowledge that this release shall not apply to any claims related to gross or willful/ wanton/ criminal /intentional acts of those who are otherwise released hereby.* This release shall also be binding upon your heirs, executors, and administrators.

5.Freedom of Consent. This notice contains our policy with respect to our security and privacy practices. This policy and notice may change at any time, but material modifications will only be effective after you have been given the opportunity to (i) review the amended policy, and (ii) withdraw your consent. You acknowledge that you have read this document in its entirety (or that it has been read to you), and that you understand and agree to the above. Your permission to perform this Laboratory Health Screening is given voluntarily on behalf of your dependent and extends to all screening personnel. You also fully understand the attendant risks and discomforts and have had an opportunity to ask questions that have been answered to your satisfaction.
To agree to participate in this Laboratory Health Screening, please sign and date this consent and release form. We cannot process your Laboratory Health Screening Test(s) unless you have signed and dated below. Thank you.

_____

Signature of Parent or Legal Guardian Date

Ver. MC1.1 (Oct/2018)