**PATIENT LABEL REQUIRED**

**PLACE PATIENT LABEL IN THIS BOX**

# SEATTLE/KING COUNTY CLINIC
# PATIENT CONSENT FOR CARE & LIABILITY WAIVER

Seattle/King County Clinic volunteers may not be able to provide you with all the health care services you need, as not all possible health care procedures are available at the clinic and care is only provided over a short period. With that understanding, if you would like to consult with the volunteer team and receive the types of treatment being offered today, PLEASE READ THE PATIENT WAIVER BELOW VERY CAREFULLY. *If you do not sign and submit the waiver you will not receive services at the Seattle/King County Clinic.*

**ACKNOWLEDGEMENT OF SERVICE LIMITATIONS:** While the volunteer health care professionals offer high quality procedures using proper equipment, I understand that because of the number of people needing treatment, I might not receive all the procedures or services I need. I understand that I might have certain health conditions that would prevent me from having the type of treatment I am requesting. I also understand that the health care providers are volunteers, some from out-of-town, and are not available for free follow-up care in the event of complications. I understand that I am solely responsible to follow up on any recommendations to seek any follow-up care I might need from a local health care provider, community health center or hospital emergency room.

**CONSENT FOR HEALTH CARE:** I hereby authorize the health care providers of the Seattle/King County Clinic, some of whom may be students closely supervised at all times by licensed professionals, to examine and treat me.

**PICTURES/VIDEO:** I grant the City of Seattle/Seattle Center, Seattle Center Foundation and their agents the right to use my picture, voice and other reproductions of my physical likeness in connection with advertising or publicizing Seattle/King County Clinic services and its activities in all media form in perpetuity.

**HEALTH SAFETY PRECAUTIONS AND RISK OF EXPOSURE:** While Seattle/King County Clinic uses proper health safety measures, I understand that in this public setting I may be exposed to COVID-19, influenza, and other infectious diseases. I agree to abide by safety requirements.

**CONSENT FOR HIV, HEPATITIS B AND C TESTING:** If a Seattle/King County Clinic health care professional, worker or volunteer is directly exposed to my blood or body fluids in a way that may transmit disease, I consent to blood testing, at no cost to me, for human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. I understand a physician or other health care provider will communicate the result of the test to me. I further consent to the release of the test results to the exposed person.

I understand if I am directly exposed to blood or body fluids of a Seattle/King County Clinic health care professional, worker or volunteer in a way that may transmit the disease, that person's blood will be tested for human immunodeficiency virus, as well as for Hepatitis B and C. A physician or other health care provider will inform me of the results of the test.

**PATIENT WAIVER:** In consideration of the free health care services received at the Seattle/King County Clinic, I, for myself, my spouse, legal representatives, heirs, executors, administrators and assigns, do hereby waive and release the City of Seattle, Seattle Center Foundation, clinic sponsors, partners and their respective employees, officials, officers, agents, and volunteers from any and all claims and causes of action for damages, attorney's fees, costs, loss of use, loss of services, expenses, compensation, consequential damage or any other thing whatsoever arising out of such free care, including but not limited to medical, surgical, dental and/or vision care or other health care or medical advice. I further understand that I am responsible for the cost of all subsequent tests, treatments, dental, vision and medical care.

**CODE OF CONDUCT:** I agree: 1. To be respectful of others - volunteers, patients, patient guests and staff; 2. To follow behavioral and procedural expectations determined by the Seattle/King County Clinic Directors; 3. That aggressive behavior, or threats of aggressive behavior, and/or violence will not be tolerated and are grounds for immediate removal; 4. To not bring alcohol, illegal drugs or weapons on the premises.

**NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received a copy of the Seattle/King County Clinic Notice of Privacy Practices.
I certify that I have read, or had read to me, and understand and agree to all of the above. I understand that by signing below I am signing a waiver and release and may be giving up important rights which I may otherwise have. I am signing this release of my own free will. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

***Patient Signature:** _____ ***Date:** _____

**Representative Signature:** _____ **Date:** _____

***Required***

| **Print patient information for healthcare record and mailing needs such as lab results or eyeglasses. Information will be kept private.** | | | |
|---|---|---|---|
| ***Patient First Name** | **Middle Name** | ***Last Name** | |
| **Mailing Address** | | | **Apt/Unit** |
| **City** | | **State** | **ZIP Code** |
| ***Date of Birth** month / day / year | **Phone** ( ) | **Email** | |