Name: _____

Date of Birth: _____

Date: 9/24/19

25500 Medical Center Dr. • Murrieta, CA 92562 • 951-696-6000

INFORMED CONSENT AND RELEASE
NO-COST PROSTATE EXAM SCREENING

I, _____, hereby
Print Name

give Consent for receipt of a Prostate Screening, provided by **Benjamin Larson, M.D., Sreenivas Vemulapalli, M.D., and Southwest Healthcare Medical Center** on **September 24, 2019**. I understand that this Prostate screening consists of a digital examination of the prostate gland ("DRE") conducted by **Dr. Larson or Dr. Vemulapalli.**

I understand that the results of the Prostate screening will be confidentially shared with me, and that it is and will be my sole responsibility to follow up with my own physician regarding the results of the Prostate screening, including any recommended care or treatment indicated by the results of the Prostate Screening.

In exchange for this no-cost Prostate screening, I hereby agree that I will hold harmless all the screening providers, from and against any and all claims and demands of any kind arising out of the Prostate screening. I understand that I may receive a copy of this signed Consent upon request.

Signed this **24th day of September, 2019** at Murrieta, California.

_____
Signature