

**Venous Screening Program**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***By signing this agreement I give consent to the physicians, medical staff and employees of Utah Vein Specialists to provide a screening for venous disease. I further understand that this screening does not constitute a complete medical exam or diagnosis. I hereby release the screening provider from all responsibility in connection with the screening exam.***

***Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date).***