

CONSENT FOR SCREENING and RELEASE OF INFORMATION

I consent to participate in this voluntary community memory screening, sponsored by **Buckner Retirement Services, Inc.** and **Dementia Screening, Inc.**

I acknowledge that my results will be sent to my physician (designated below) during the week following the screening. I also recognize that this screening battery is not a full neuropsychological evaluation and will not provide definitive information regarding diagnosis. It will however give my doctor a basis of information on which to make further decisions regarding my health care.

I hereby authorize **Dementia Screening, Inc. and Buckner Retirement Services, Inc.** to release all pertinent records relating to the results of the screening of the undersigned to the physician designated below. I also release **Dementia Screening, Inc. and Buckner Retirement Services, Inc.** from all legal claims, damages or causes of action of any kind -that may arise from such screening and release of records. It is understood that the release of information by **Dementia Screening, Inc. and Buckner Retirement Services, Inc.** is protected by policies established for maintaining the confidentiality of records.

PATIENT NAME: _____
(Print Name)

Patient/Parent/Guardian Signature **DATE:** _____

Witness Signature

Send To (Primary Physician):

(Name)

(Address)

(City, St, Zip)

(Phone)