



HEALTH-LINK LABORATORY

-----Where Health Meets Priority-----

COMMERCE HOUSE, MOI AVENUE, 6TH FLOOR RM 610b

Tel. No; 0725 921 024. Email. www.healthlinklabs.uniqeventures.co.ke.

DATE

NAMES;

ID/PP NO;

AGE;

CONTACT;

AGENCY;

AGENT'S NUMBER;

PATIENT CONSENT FORM, DECLARATION AND TERMS & CONDITIONS OF SERVICE

THIS DECLARATION is made on this ____ day of _____ 20 ____ by the undersigned patient (hereinafter referred to as "the patient").

1. CONSENT TO MEDICAL SERVICES

I hereby give my informed and voluntary consent to the provision of medical services, diagnostic tests and (imaging procedures if required) by Health-link Laboratory.

I acknowledge that such services are provided strictly for diagnostic and medical purposes only.

2. CONFIDENTIALITY AND DATA PROTECTION

I acknowledge and agree that all my personal, medical, and health-related information shall be treated as confidential and shall be collected, processed, stored, and used solely for legitimate medical purposes. Such information shall not be disclosed to any third party without my prior written consent, except where disclosure is required by law or is necessary in the event of a medical emergency, in accordance with applicable data protection and privacy laws.

3. NO AFFILIATION OR GUARANTEE

I expressly acknowledge that the laboratory is not affiliated with, nor does it act as, an employment agency, travel agency, immigration consultant, or visa service provider. Any referral to the laboratory does not create such an association. I further acknowledge that the laboratory does not provide visa services, immigration assistance, or any guarantees relating to employment, travel, or visa outcomes.

4. DECLARATION OF 8COUNTRY OF TRAVEL

I confirm that I am required to accurately declare and inform the attending medical personnel of my intended country of travel, where applicable, to enable the laboratory to conduct the appropriate medical examinations and tests.

5. FEES AND NON-REFUND POLICY

I understand and agree that all medical services are provided strictly on a pre-payment basis and that all fees paid are non-refundable, whether or not the services are completed, and under no circumstances shall refunds be issued.

6. ACCURACY OF INFORMATION

I undertake to provide full, accurate, truthful information to the medical personnel to facilitate, proper diagnosis and medical evaluation. I acknowledge that the provision of incomplete, inaccurate, or misleading information may adversely affect the quality, accuracy, or outcome of the medical services provided, and I accept full responsibility for any consequences arising therefrom.

7. VOLUNTARY PARTICIPATION AND WITHDRAWAL

I acknowledge that my participation in the medical services is entirely voluntary and that I may withdraw my consent at any time. However, I understand and agree that any fees already paid shall remain non-refundable notwithstanding such withdrawal.

8. INDEMNITY

I hereby indemnify, defend, and hold harmless the Laboratory, its officers, employees, and agents from and against any all claims, demands, losses, liabilities, damages, or expenses arising from or related to acts, omissions, misrepresentations, or conduct of third parties, including but not limited to referring agencies or intermediaries.

9. ACKNOWLEDGEMENT AND ACCEPTANCE

I confirm that I have read and fully understood the contents of this Patient Consent Form, Declaration, and Terms & Conditions. I voluntarily agree to be bound by the terms set out herein and undertake to comply with all applicable confidentiality and data protection obligations.

PATIENT DETAILS

Full Names: _____

ID/Passport No: _____

Signature: _____

Date: _____

FOR OFFICIAL USE
