

Health Quarters
PREGNANCY TEST REQUEST FORM

Today's Date: _____

I hereby voluntarily request Health Quarters to test for pregnancy. I understand that the earlier the test, the greater the chance of error, and that the test results should be confirmed by a physical examination.

I further understand that the correctness of the result of the pregnancy test is not guaranteed whether positive or negative.

I understand that I should seek follow-up care from an appropriate provider:

- Within 15 days of the test if I am considering an abortion.
- Within 15 days of the test if I am considering continuing with the pregnancy.

If problems arise, I should see a medical provider sooner.

I have been informed that an examination is necessary to determine the length of time I have been pregnant and whether the pregnancy is progressing normally.

I hereby release Health Quarters, and its clinical staff and employees from any and all liability arising out of or connected with this pregnancy evaluation with regard to any errors in the diagnosis.

I give permission to Health Quarters to use information obtained in my record for statistical purposes with the understanding that confidentiality will be maintained.

I acknowledge that I have received a copy of Health Quarters' "Notice of Privacy Practices."

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____