CLINIC CONSENTS

Patient name: _____ **date of birth:** _____

SERVICES CONSENTS

The information provided is true to the best of my knowledge. I request and authorize the Noble County Health Department (NCHD) and its personnel to deliver medical care to me or my child listed.

FINANCIAL POLICY

I further authorize my insurance benefits be paid directly to the provider. I have received the Patient Financial Policies and understand that I am financially responsible for any balance. I also authorize the NCHD or insurance company to release any information to process my claims.

NOTICE OF PRIVACY POLICIES

I have been given the opportunity to review a copy of the Noble County Health Department Notice of Privacy Practices (HIPAA).

CONSENT FOR SHARING INFORMATION

I give permission for the Noble County Health Department to share information such as, but not limited to, my immunization record, hemoglobin, height, and weight with their other programs as well as with my school district and the Ohio Department of Health immunization Program. I know this information will include my name, address, phone number and date of birth. This information will only be used for updating of records or referrals. It will be kept confidential by all programs involved. I know I am not required to consent to the sharing of this information. If I decline to consent, my refusal will not affect the services I receive.

IMMUNIZATION CONSENT

I have received a copy of the Vaccination Information Statement. The information has been explained to me and I was given a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and I consent for the vaccine(s) to be given to me or the minor for whom I am authorized to make this request. I give permission to release the immunization record to the Ohio Department of Health Immunization registry. I understand that it is recommended to wait 15 minutes at the clinic following vaccination.

RELEASE OF INFORMATION

I authorize the following individuals to access my/my child's medical record.

1. _____ Relationship to patient _____
2. _____ Relationship to patient _____

By signing, I agree to the above statements.

_____	_____	_____
Print name	Signature of Patient or Parent/Guardian of minor	Date