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 services, care, and treatment to me or my child listed. Confidentiality will be maintained. Referrals will be made if needed for further diagnosis, testing, or treatment.

REPRODUCTIVE HEALTH / FAMILY PLANNING / TITLE X SERVICES

I understand that reproductive health services provided by the NCHD are voluntary and clients are not coerced to accept services. NCHD reproductive services are not a prerequisite for acceptance or eligibility for any other program. I consent to having my female/male reproductive systems (breast, pelvic, genitals, rectal, prostate, cervix) examined if medically indicated. I understand that if sexually transmitted infection test(s) are positive then it is required by law to report certain information to the Ohio Department of Health. NCHD RHWP services may use telehealth services if medically appropriate. Confidentiality for telehealth services will be maintained on the NCHD end; however, you may need to check your security settings or be in a private area for your confidentiality to be upheld on your end.

FINANCIAL POLICY

I further authorize my insurance benefits to 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 and possibly my school district and the Ohio Department of Health immunization Vaccine Registry if appropriate. I know this information may 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**