**Consent for Medical Services and Personal Health Counseling & Acknowledgement of Privacy Practices**

* I hereby voluntarily request and authorize medical examination and treatment by the clinical staff at ­­­\_\_\_\_\_\_\_\_\_\_\_Health Center.
* I give permission to \_\_\_\_\_\_\_\_\_\_\_Health Center to use information obtained in my medical record for statistical purposes with the understanding that confidentiality will be maintained.
* I understand that if I test positive for a reportable communicable disease, \_\_\_\_\_\_\_\_\_\_\_Health Center is required by law to report my name to the Department of Public Health.
* I have read this consent entirely and I understand its contents.
* I acknowledge that I have received a copy of \_\_\_\_\_\_\_\_\_\_\_Health Center’s Notice of Privacy Practices.

**For those who are under the age of 18, elderly or disabled:**

\_\_\_\_\_\_\_\_\_\_\_Health Center will make every attempt to preserve your confidentiality. However, there are certain circumstances under which we are legally and ethically required to notify a parent, legal guardian or custodian.

* I understand that if I am a minor diagnosed with a potentially life threatening condition or found to have a serious medical problem, parental notification is necessary.
* I understand that the staff at \_\_\_\_\_\_\_\_\_\_\_Health Center are “mandated reporters”, meaning if I reveal any experience of abuse and/or neglect by members of my family or guardians, the Department of Social Services will be notified. Further investigation by them may or may not occur.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_