NAME	DOB	CHART #

POLK-NORMAN-MAHNOMEN COMMUNITY HEALTH SERVICES
CONSENT FOR SEXUAL & REPRODUCTIVE HEALTH SERVICES

CLIENT CONSENT FOR SERVICES:

- I authorize Polk-Norman-Mahnomen Community Health Services to provide services that may include:
  - Prescription or over the counter medication
  - Lab testing as indicated: Hemoglobin, Urinalysis, Pap Smear, STI (sexually transmitted infection) testing, Pregnancy testing, HIV, Hepatitis C, Syphilis or other lab work
  - Height, Weight, Blood Pressure, BMI, and Physical Examination (including pelvic and breast examination).
- I am aware that my medical care will be provided by physicians, physician's assistants, nurse practitioners, registered nurses or allied health professionals from Polk County Public Health and/or Norman-Mahnomen Public Health. I hereby release Polk County Public Health and Norman-Mahnomen Public Health of any and all liability for any adverse results, which may occur from my use of any contraceptives/ medication/device and/or services.
- I understand that Polk-Norman-Mahnomen Community Health Services charges a fee for the services provided. A list of these charges is available upon request. These charges may be discounted based on my income and/or family size.
- I understand that payment is requested at the time of my visit. I agree to contribute to the cost of my services. If I cannot pay in full, I will make arrangements to pay my unpaid balance as soon as possible or discuss this with the staff member.

CONSENT FOR DISCLOSURE AND USE OF INFORMATION:

The Minnesota Data Practices Act, M.S. 13.04, Subd.2. (TENNESSEN WARNING) requires that we inform you of the purpose and intended use of any information we request from you, who has access to the information we record, whether you are legally required to supply any requested data, and any "known consequence" from supplying or refusing to supply private or confidential data.

- I understand all information provided, recorded and or released by Polk-Norman-Mahnomen Community Health Services concerning myself or my family will be private and may be used only for the following purposes:
  - To determine eligibility of services
  - To provide background information for the provision of services
  - To determine the amount of payment for services (if any)
  - To collect statistical information identifying community problems (According to Minnesota state law, Rule 4605.7040, the following STIs are reportable to the Minnesota Department of Health: Chlamydia, Gonorrhea, Syphilis, Chancroid, and HIV. I understand if my test is positive for any of these sexually transmitted infections it is required to obtain and report the following information:
    - My name, Date of Birth, Address, Phone Number, Ethnicity, Race, and Country of Birth
    - Names, Addresses, and Phone Numbers (if known) of untreated sexual partner(s) in the past 60-90 days.
  - To be forwarded to the courts if subject to order
  - To substantiate reimbursement claims of the county
  - To obtain case consultation when necessary
  - To provide or exchange information with the following agencies or individuals about client status when necessary:
    - Other Public Health program staff
    - Medical Providers
    - Other (s): _____
- I understand that I am not legally required to provide this information or authorize a release. However, I further understand that if I fail to provide this information or to authorize a release, such failure may result in a delay in providing or a denial of service.
- I understand that as a subject of collected data, unless otherwise specified by law or court order, I may view the information concerning me. Copies of this information may be made, for a reasonable fee, upon written request.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

- **I understand my medical records are confidential. No medical record information will be released without my written consent, except in the case of emergency or as required by law. I authorize the release of any medical or other information necessary to process insurance claims.**
- **I have received a copy of the Polk-Norman-Mahnomen Community Health Services Privacy Notice. I have had an opportunity to have my questions answered.**
- **I do hereby freely and knowingly give my consent to Polk-Norman-Mahnomen Community Health Services to use personal information for the purposes described above. This consent will terminate one year from this date.**

Client Signature:		Date:	
Staff Signature:		Date:	