

PATIENT # \_\_\_\_\_



Burlington (319) 753-2281, Keokuk (319) 524-2759, Ft. Madison (319) 372-1130  
Mt. Pleasant (319) 385-4132, Washington (319) 653-3525, Wapello (319) 527-4211

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in *Planned Parenthood of Southeast Iowa's Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

**I hereby acknowledge** receipt of *Planned Parenthood of Southeast Iowa's Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

Signature of patient \_\_\_\_\_

Date \_\_\_\_\_

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of staff \_\_\_\_\_

Date \_\_\_\_\_

**Medical Consent**

I-B-2a

PPSI Implemented May 2009

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
<p>Signature of any other person consenting _____</p> <p>Relationship to patient _____</p> <p>Date _____</p> <p>I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.</p> <p>Signature of witness _____</p> <p>Date _____</p>	