



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

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

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), and procedure(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 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 Western New York, Inc. (PPWNY) *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 request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment.

I understand that PPWNY's Provider(s) works out of two hospitals, Niagara Falls Memorial Medical Center and Mt. St. Mary's Hospital in Lewiston. In order for PPWNY's Provider(s) to render care, it is necessary to use one of these hospitals. I understand

that if my child receives care at any other hospital, PPWNY's Provider(s) will be available to Staff Physicians by phone only and that he/she will resume care for my child upon discharge from the hospital.

Planned Parenthood of Western New York's staff needs to know if anyone other than you might be bringing your child in for care. PPWNY cannot give immunizations without a parent or legal guardian's permission in writing.

Please document below the following people who may bring your child to PPWNY for care as stated above:

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I hereby acknowledge receipt of Planned Parenthood of Western New York's notice of health information privacy practices Patients' Bill of Rights, and Health Care Proxy.

Signature of Parent or Guardian _____

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 Witness _____

Date _____