Morris County Health Department
FAMILY PLANNING CONSENT FOR TREATMENT

1. I give my consent to the Morris County Health Department (MCHD) to obtain a health history, secure laboratory services, and perform a physical examination for me as indicated.

2. I also herby give my consent to the MCHD to test for sexually transmitted diseases they consider appropriate, including but not limited to Chlamydia, gonorrhea, syphilis, genital warts, herpes, trichomoniasis, and monilia (yeast). I understand that testing for Human Immunodeficiency Virus (HIV) is available on a volunteer basis. I understand that if I am found to be infected and treatment is not through this health department, I will be referred to a physician of my choice. I understand that positive test results require treatment, and may warrant a possible confidential follow-up by a public health worker.

3. The MCHD will provide services as outlined by written protocols that have been reviewed by the Family Planning Medical director.

4. The MCHD and the contracted physicians will exchange medical information as needed to provide quality
health care and maintain the medical data.

5. I agree to accept the following responsibilities:

A. I will notify the MCHD if I have any problems or concerns regarding my health status.
B. I will keep my clinic appointments as scheduled and if I am unable to keep my appointment I will call the health department at least 24 hours in advance.
C. I will notify the MCHD if I plan to leave the area or transfer to a new medical provider.
D. I will provide documentation of income annually or whenever there are changes.
*If income information is not current, fees will be charged at 100%.

6. I understand my visits are confidential and private, and my care will not be discussed with anyone outside of MCHD unless I give my written permission to do so. I understand the following exceptions to these confidentiality rights of treatment for the protection of both myself and the public.

A. **Age 17 and under:** I understand the following additional exceptions to my confidentiality rights may occur: If a life-threatening condition is identified and I am unwilling or unable to follow-up on referrals, Clinic staff may notify a parent or legal guardian.
B. If, in the course of my visits to the clinic, a staff member thinks I may cause harm to either myself, or someone else, the potential victim or authorities must be notified
C. Clinic staff are required by law to report suspected cases of child abuse or neglect.
D. If I am involved in a legal matter, it is possible to get my clinic records subpoenaed.

7. I am voluntarily consenting to receive the services provided by this clinic.

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Signature of Patient Date