

## Health Quarters

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

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- I hereby voluntarily request and authorize medical examination and treatment by the clinical staff at Health Quarters.
- I am aware that, although the highest possible quality of medical care will be provided, no absolute assurance can be made to me concerning the results of any medical services.
- I understand that Health Quarters is not responsible financially for medical problems resulting from use of any contraceptive or medication prescribed for me by Health Quarters
- I give permission to Health Quarters 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 Quarters 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 Quarters' Notice of Privacy Practices.

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

Health Quarters 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 Quarters 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: \_\_\_\_\_