1. Last Name	First Name	MI

2. Patient Number									

3. Date of Birth (MM/DD/YYYY)									
	Month		Day		Year				

4. Race ☐ American Indian or Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Unknown ☐ White

5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American
☐ Hispanic Other ☐ Hispanic Puerto Rican
☐ Not Hispanic/Latino ☐ Unreported

6. Gender ☐ Female ☐ Male

7. County of Residence

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Family Planning and Reproductive Health Unit

Family Planning
General Consent for Services

I agree to be a patient: I am choosing to become a patient and get services from the Family Planning Clinic of my own free will and receiving family planning services is not a prerequisite to receiving any other services offered in the health department. I hereby consent to services that may include:

- A physical exam
- Lab tests (which may include screening for syphilis, HIV, gonorrhea, chlamydia, cervical cancer)
- Birth control supplies and education
- Treatments and tests which are felt needed by the healthcare provider

Confidentiality (Private): I know that my medical information is private and is protected by state and federal confidentiality laws. Staff will not share this information unless:

- I tell the staff in writing that they can share it
- It is an abnormal test result that needs to be shared with a healthcare provider at another clinic or agency in order to provide my follow up care
- It is shared for treatment, payment or health care operations, as explained in the Notice of Privacy Practices
  - An example of sharing for treatment is communicating with other clinics you go to about your care
  - An example of sharing for payment is billing your Medicaid or health insurance plan for services
  - An example of sharing for health care operations is medical records reviews by state auditors
- It is required by law
- If you are under age 18, your information will not be shared with your parent or guardian without your permission, unless your health care provider thinks that sharing the information is absolutely necessary for your life or health. In this case, your health care provider will contact you before sharing information, unless it is an emergency or you cannot be reached.

Follow up: I know that if any problems are found, suggestions will be made to me concerning follow up and it is up to me to follow up. I will let the Health Department know of any changes in my address and/or telephone number so that I may be contacted quickly, if needed. If my exam or lab work shows any problems, staff may send me to another clinic for help, if needed.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Patient Date

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual in choosing her birth control method:

I have translated the information and advice presented orally to the individual to use the above contraception by the person obtaining this consent. I have also read her the consent form in _____ language and explained its contents to her. To the best of my knowledge and belief, she understood this explanation.

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date

_____ _____/_____/_____
Interpreter Date