MYHEALTH AUTHORIZATION FOR SERVICES

(Please Print)

Date: _____ Chart Number: _____

Name: _____ Birth date: _____

I agree that a person authorized by the MyHealth examines me and provides an appropriate testing and treatment. I understand that I can stop my appointment at any time. I understand that I am responsible:

1. to understand the condition that I'm being examined for and treated;
2. to understand the side effects and consequences of my condition and/or treatment;
3. to use any treatment prescribed or recommended for me in the way that I was instructed by the clinic staff;
4. to follow through with recommended treatments, including follow-up visits if necessary.

I understand that MyHealth may use and disclose my protected health information without authorization for treatment, payment or health care operations. *Protected health information* is individually identifiable information we create or receive, including demographic information, information about your physical or mental health, health care services provided to you, and collection of payment for providing services to you.

We are also required by law to pass on information about you in the following situations:

- if you are diagnosed with Chlamydia, Gonorrhea, Syphilis or HIV, we must contact the Minnesota Department of Health (this information is used to keep statistics on STDs in Minnesota, to help people get treatment for STDs if they have a problem and to confidentially notify your sexual partners about the need for STD testing if you aren't comfortable doing this). They will not call your parents or guardians.
- If a clinic staff person is concerned that you are being abused.
- If a clinic staff person is concerned that you have a plan to harm yourself or someone else, we must tell your parents, warn the other person, and/or make plans to keep you safe.

I understand that the clinic reserves the right to contact me in whatever way necessary if I have a positive or abnormal lab test result that requires some type of follow-up. The clinic will take every precaution to keep things confidential in this situation.

I understand that I may request, in writing, restriction of further use and disclosure of protected health information for treatment, payment, or health care operations (with the exception of uses or disclosures required by law). MyHealth is not required to agree to your request if it is not feasible or if we believe it will negatively impact the care we may provide you. I also understand that I have the right to revoke this consent, in writing, except where MyHealth has already made disclosures in reliance on my prior consent.

Our *Notice of Health Information Practices* provides information about how we may use and disclose protected health information about you. By signing this consent form, you have received a copy of this *Notice* and authorized MyHealth to provide medical services. If you do not sign this consent form, we have the right to refuse you treatment.

- If you understand this information, please sign your name below.
- If you don't understand everything on this page or have questions you want answered first, please talk with a clinic staff person.

_____ _____

Client Signature Date Witness Signature Date

Rev. 09/25/2013 **SHRED WHEN DONE**