3536 Holly Road
Corpus Christi, Texas 78415
361 855-9107 (ph) 361 855-6822 fax

4410 Dillon Lane, Ste 1
Corpus Christi, Texas 78415
361 857-0101 (ph) 855-0003 fax

1000 S. 14th St, Ste 1022B
Kingsville, Texas 78363
361 595-1875(ph) 595-1879 (fax)

2041 E Main St, #300
Alice, Texas 78332
361-453-4221

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.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(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 Women's and Men's Health Services of the Coastal Bend.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

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 WAMHS' *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 WAMHS provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Women's and Men's Health Services of the Coastal Bend's notice of health information privacy practices.

Signature of Patient_____ 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_____

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CONSENT FOR MEDICAL TREATMENT OF A MINOR

Name of Minor_____ Birth Date_____ Age_____

Consent by Parent/Managing Conservator/Guardian or other Adult

Name of Parent or managing conservator/guardian_____

I am the (check one): parent____ managing conservator_____ guardian_____ of the above minor.

I give permission for WAMHS to provide the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of her choice, based on consultation with the health provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use. This consent begins on the date below and remains in effect unless revoked in writing. I declare under penalty of perjury that the above information is true and correct.

_____ _____ _____

Printed name of person giving consent Signature of person giving consent ate

Complete this section only if the parent/managing conservator/guardian CANNOT BE CONTACTED.

The person having the right to consent to medical treatment for the above minor cannot be contacted and has not given notice to the contrary. As per Texas Family Code Chapter 32.001, I may consent for medical treatment of the above named minor. I am the (check one)

_____ grandparent _____adult brother/sister _____adult aunt/uncle
_____ educational institution with authorization to consent from the person having the right to consent
_____ adult with care/control/possession with written authorization to consent from the person having the right to consent
_____ adult responsible for minor under juvenile court order
_____ Texas Youth Commission staff

I give permission for WAMHS to provide the minor named above confidential medical treatment. This includes permission for the minor child named above to give informed consent for the birth control method of her choice, based on consultation with the health provider. I waive my right to review and sign a consent form for the birth control method the minor chooses to use. This consent begins on the date below and remains in effect unless revoked in writing. I declare under penalty of perjury that the above information is true and correct.

_____ _____ _____

Printed name of person giving consent Signature of person giving consent Date