

My signature below acknowledges that I am choosing to receive confidential medical services and/or education from Panhandle Health District (PHD). I hereby request and authorize the clinic to provide available health care services deemed necessary by the PHD clinic staff. These services may include but are not limited to: Evaluation of my medical and family history, physical examination, laboratory tests, which may or may not include STI testing and/or HIV testing, X-rays or photographs, medications or prescriptions, injections or immunizations, minor surgical procedures, and counseling services.

I understand that no test is perfect and all tests may fail to detect a problem (false negative) or suggest a problem when none exists (false positive).

Since some medical conditions may affect my care, it is my responsibility to give as complete and accurate a medical history as possible. If new problems that may be related to my condition or care arise, I understand I should inform the clinic of this. I understand that it is my responsibility to seek care elsewhere for any other medical problems beyond what is provided by the PHD clinic.

I understand that I have a right to refuse any procedures or services that are recommended. Refusing some types of care will not jeopardize my receiving appropriate care for other problems or concerns.

I know that all services provided by the clinic are confidential. However, I understand that the results of some tests for sexually transmitted infections and other diseases must be reported to the State Health Department in a confidential manner, as required by law. I also understand that if I am under age 18 and have been a victim of abuse, the law requires it be reported to the proper authorities.

I give my permission to PHD to provide the results of my care to my health care provider or the referring provider for the purpose of medical care. I understand that I am responsible for charges not covered or paid by my health insurance and give permission to release information to my health insurance company.

I give my full consent for PHD to send me appointment reminders via text messages at the following number:

TEXT number: _____

The undersigned has read, fully understands, and agrees to all of the above provisions and information in this document. This consent is in effect for a period of one (1) year from date of signature.

Patient Signature: _____

Date: _____