Midland County Health Department
Consent for Services and Release of Information

Client ID#:
Client Name: DOB: Age:_____

Midland County Health Department, its employees or agents may provide applicable services, examination and/or diagnostic testing or treatment. These services are provided confidentially, on a voluntary basis, without my being forced to accept any services or medications.

I understand that information from my record may be shared with the members of my treatment team. My treatment team will be determined by the services I receive, and may include, but is not limited to, a nurse, nurse practitioner, or doctor. In the event of an infestation or infection of a school-aged child, my child's school may be contacted. Childhood immunizations may be shared with the Michigan Childhood Immunization Registry. Any other release of information will require a specific release, signed by the client, custodial parent or guardian, unless the information is otherwise legally required.

I understand that I do not need to receive family planning services to get other services or support from the health department.

Midland County Health Department may release, either verbally or in writing, information contained in my medical, social, or educational records, including HIV, AIDS, or AIDS related information, as is necessary for the authorization and payment of bills for professional services.

I understand that I am responsible for charges due the Health Department and that payment is expected at the time of service.

If a Health Department employee is exposed to blood or body fluids by puncture, or consent to open skin or mucus membrane, the client's blood may be tested for HIV and other infectious diseases without further consent.

As a partner in my health care, I understand that participation and follow through is expected. Services may be terminated due to noncompliance. Examples of noncompliance are: not being at home two times for scheduled home visits, failure to pay fees for which I am responsible, or failure to follow a prescribed treatment.

This authorization will continue in effect through the duration of service associated with this admission or condition, up to one year, or until revoked in writing.

Print Name of the Person authorizing consent

_____

Custodial Parent, Guardian or Client (circle one)_____

Signature:_____ **Today's Date**_____

Clerk's Initials_____