CONSENT FOR REPRODUCTIVE HEALTH SERVICES

I, (print or type name) _____, request family planning services from the _____ Health Department. I understand that I will give a medical history, have a physical examination, and may get several tests including but not limited to:

- Measurement of height, weight, and blood pressure
- Breast examination – for tumors and abnormalities
- Pelvic (vaginal) examination
- Pap test (Papanicolaou smear) – a screening test for cancer of the cervix and related conditions
- Male genital examination
- Tests for gonorrhea, chlamydia, and human papillomavirus (sexually transmitted infections)
- Urine test to check for diabetes and urine infection
- Urine and/or blood tests to check for pregnancy
- Blood tests to check for syphilis, anemia, and immunity to rubella
- Blood test for hemoglobin disorders
- Blood test for HIV (AIDS) infection
- Skin test for tuberculosis (TB)

I understand my health information is confidential. Confidential means that no one outside of the Health Department will be told about my visits or given information about my health care without my written permission. I understand that in certain cases (suspected child abuse/sexual abuse, child neglect) confidentiality cannot be kept because of Maryland law.

I request information about the different types of family planning methods which are available to me. I understand that these methods include, but are not limited to: fertility awareness methods, condoms, diaphragm, spermicide (vaginal film, foam, or gel), birth control pills, emergency contraception pills, intrauterine device (IUD), birth control "shot" (Depo-Provera), birth control skin patch (Ortho Evra), vaginal ring (NuvaRing) and skin implant (Implanon). With the help of my clinician I will decide on the family planning method which is best for me.

If it is found that I have a sexually transmitted infection, bladder infection, or other infection, I may request treatment for the infection.

If my test for gonorrhea, chlamydia, syphilis, or HIV is found to be positive, I understand that, by law, this result will be reported to the Division of Communicable Diseases of the Maryland State Department of Health and Mental Hygiene.

I understand that my health is my responsibility. I agree to call the family planning clinic for regular check-ups and to find out the results of my lab tests. I will tell the clinic if I change my address, phone number, or contact information. If I decide not to return to the clinic, I will seek care from another provider.

I understand that information in my health record may be disclosed in summary, statistical, or other forms without my consent when the information does not identify me by name.

I voluntarily agree to have family planning services. I understand that I may withdraw this consent at any time.

I understand and agree with the above statements.

Date: _____ Client Signature: _____

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If translation of CONSENT FOR FAMILY PLANNING SERVICES was required:

- A translator was offered to the client. □ yes □ no
- The client chose to use his/her own translator. □ yes □ no
- This form has been orally translated to the client in the client's spoken language.
- Language translated: _____
- Translation provided by: _____
  (print or type name of translator)
- Translator employed by, or relationship to client: _____
- Date: _____ Translator Signature: _____

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- The client has read this form or had it read to him/her by a translator or other person.
- The client states that he/she understands this information.
- The client has indicated that he/she has no further questions.

Date: _____ Staff Signature: _____