# RECEIPT OF NOTICE OF PRIVACY PRACTICES
# PORTSMOUTH CITY HEALTH DEPARTMENT

**Patient Name:** _____ **Medical Record #**_____

**My signature on this form acknowledges that I have received a copy of Portsmouth City Health Department's (PCHD) Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by PCHD and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.**

_____ _____
Patient's signature Date

_____ _____
Signature of Patient's Representative Date
if patient is unable to sign

**BE COMPLETED BY HEALTH DEPARTMENT EMPOLOYEE IF FORM IS NOT SIGNED**

1. Was the patient provided with a copy of the agency's Notice of Privacy Practices? ☐ Yes ☐ No
2. Briefly describe efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or willing to sign this form:_____

_____

_____

_____ _____
Signature of Health Department Employee Date

# CONSENT FOR MEDICAL TREATMENT AND
# POLICY FOR NOTIFICATION OF POSITIVE TEST RESULTS

I am requesting clinical, educational, and/or social services of the Family Planning Health Services Clinic as a free and voluntary act deed. I do hereby give my consent for medical examination, including blood test and other lab tests, which are deemed advisable by the nurse practitioner. These include tests for sexually transmitted diseases and other medical conditions as necessary. I understand that in the event of a positive or questionable test, I may be contacted and have treatment for my partner and myself. The process for notification includes phone calls and the final and third attempt to contact me may be a registered letter sent to the address that I provide the clinic. I have been advised that no contraceptive method is 100% effective in all cases and that side effects may occur. I understand that it is my responsibility to bring to the attention of the nurse practitioner any unusual symptoms while I am using a contraceptive method and hereby release the City of Portsmouth Family Planning Health Services Program from any and all claims which may have resulted by reason of their providing medical, educational and/or social services.

Family Planning Clinic hours of operation are Monday through Friday, 8 am to 4:30 pm. The Family Planning Clinic does not have On-Call Services or After Hours Care. For all non-emergency conditions, leave a message on our voicemail at 353-8863 and we will return your call as soon as possible. For all emergencies, go to the nearest Emergency Department. The Southern Ohio Medical Center's Emergency Department is located at 1805 27th St., Portsmouth.

_____ _____
Patient signature Date

_____ _____
Witness by clinic staff Date