PATIENT AUTHORIZATION

Label

- I acknowledge I was offered a copy of the Notice of Privacy Jackson County Department of Public Health describing how my protected health information may be used or disclosed as permitted by state and federal law. I understand that I may revoke this authorization at any time. I understand that this consent is valid for one year unless I revoke it in writing.
- I acknowledge that Telemedicine may be offered as an alternative method of medical care. Telemedicine involves the use of electronic communication between the JCDPH and myself. This communication may be used for diagnosis, follow-up and/or education. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- I understand that payment for services is expected at the time of service. As a courtesy, the JCDPH may bill my insurance for some services.
- I understand that fees for services may be reduced or waived upon verification of income eligibility. Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, my income statement is true and correct.
- I understand that the information on the income statement may be checked by a state reviewer, and I agree to provide the financial records required to carry out the review.
- I understand that my signature will serve as legal "signature on file" for purposes of filing my insurance claims and payment of medical benefits to the JCDPH for services rendered.
- I voluntarily give my consent for the JCDPH to use and/or disclose protected health information for purposes of treatment, payment, and health care operations.
- I understand that the health/medical information used and disclosed for treatment, payment, or health care operations may include information of a private and sensitive nature (such as STD's).
- I understand, as part of visit, some laboratory services may be necessary that the JCDPH is unable to complete in the clinic. If a laboratory performs a service for me, I understand I may receive a bill from the testing agency and I will be responsible for the cost of any laboratory services.
- I hereby voluntarily consent to the JCDPH for medical examinations, treatments and procedures which are deemed necessary in the opinion of my physician and health care providers, including HIV tests, laboratory tests and x-rays. I understand that my medical information is strictly confidential and is protected by North Carolina General Statute 130A-143. No guarantees or warrantees have been made to me concerning the results of the examinations, treatments or procedures. My signature acknowledges that I have been given the opportunity to ask questions about this consent form and the opportunity to refuse services for me or as the verified personal representative of the individual named above.
- I understand my Wellness Screening lab results will be mailed to me/myself. I understand that it shall be my responsibility to follow–up with my medical provider regarding these results. JCDPH will send a copy of abnormal results to my provider.
- My signature acknowledges that I have been given the opportunity to ask questions about this consent form, and that I have been given the opportunity to refuse any or all services.

- **I give JCDPH permission to bill my insurance carrier should my diagnosis and/or treatment include STD services.**
  ☐ Yes, I give permission ☐ No, I do not give permission

********************Required Information*****************

Mail

☐ **YES -** I wish to receive mail at my home address.

My address is _____

☐**NO** - I do not wish to receive mail at my home address.

PATIENT AUTHORIZATION

Calling/Text Message

☐**YES -** I wish to receive a call/text/voicemail message. My cell phone number is _____

☐**NO** **- I do not wish to receive a message/call about my visit or results.**

Please note:

- Your cellular service may charge you a fee for transmitting and delivering text messages.
- You may discontinue receiving appointment reminders by text at any time by notifying the staff.
- Please notify the staff of any change in your phone number.

Patient Portal (Age 18 and older)

☐**YES -** I wish to participate in the patient portal. My email is _____

☐**NO** **-** I do not wish to patient portal.

Use of Online Communications

Online communications, including the Patient Portal, should never be used for emergency purposes or urgent requests. If you have a medical emergency or urgent request you should contact your physician immediately or seek appropriate emergency medical care.

Maternal Health Patients Only -Photo (Age 18 and older)

☐**YES -** I wish to have my photo taken. ☐**NO -** I do not wish to have my photo taken.

I grant / decline my permission to have my picture taken. I understand that the use of this photograph is for recognition during my appointment. At any time in the future, I may request my picture be removed from my record. Images will be stored in the Electronic Health Record and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time they will be destroyed or archived.

Minor Consent

☐ **YES -** I certify that I am: (a) at least 18 years of age (b) legally able to consent to my own health care G.S. 90-21.5 (c) the parent or legal guardian of the minor patient; or (d) the legal guardian of the patient. Further, I hereby give consent to the licensed healthcare provider to provide services including, but not limited to Sports Physical, School Health Physical, Immunizations or Laboratory services.

☐ **YES -** I have had a chance to ask questions which were answered to my satisfaction. I understand the risks and benefits of COVID-19 vaccine and request that the COVID-19 vaccine be given to me or the person named above for whom I am authorized to make this request.

Telemedicine

☐ **YES -** I wish to participate in telemedicine.

☐ **NO -** I do not wish to participate in telemedicine.

I understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

_____ _____ _____

Signature of Patient/Guardian Patient's Date of Birth Date

_____ _____

Signature of Interviewer/Witness Date

JCDPH #7513
Rev. 09/16, 01/17, 06/17, 3/18, 07/18. 07/19, 05/20, 03/22