Planned Parenthood® of Delaware

Request for Medical Services / HIPAA

❑**Dover**
805 S. Governors Ave.
Dover, DE 19904
(302) 678-5200

❑**Wilmington**
625 N. Shipley St.
Wilmington, DE 19801
(302) 655-7293

❑**Newark**
140 E. Delaware Ave.
Newark, DE 19711
(302) 731-7801

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

PUT LABEL HERE

PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Delaware's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

Please note that Planned Parenthood of Delaware is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

I hereby acknowledge receipt of Planned Parenthood of Delaware's notice of health information privacy practices.

Signature of patient _____ Date _____

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness _____ Date _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting _____

Relationship to patient _____

Date _____

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness _____

Date _____