Family Planning Informed Consent & Confidentiality Statement

I,	, hereby give my consent to,
 , hereafter referred to as the Clinic, to obtain a health history, secure laboratory services and perform a physical examination for me as indicated. The Clinic may test for sexually transmitted diseases—including but not restricted to—Chlamydia, gonorrhea, syphilis, and HIV—as indicated. I understand that positive test results may require treatment and may warrant confidential follow-up by a public health worker. I understand that if I require care beyond the scope of this Clinic I will be referred to a health care provider of my choice. I understand that my visits to the Clinic are confidential and private pursuant to the Health Insurance Portability & Accountability Act (HIPAA) and other applicable State laws, and my case will not be discussed with anyone outside the Clinic unless I give my written permission to do so, except as necessary to provide services or required by law. If, in the course of my visits to the Clinic, a staff member believes I may do harm to either myself or someone else, the potential victim or authorities shall be notified. 	
Client Signature	Date
Witness Signature	Date
 If a life-threatening condition is identical Clinic staff may notify a parent or leg 	wing additional exceptions to my confidentiality rights may affied and I am unwilling or unable to follow-up on referrals, al guardian. Kansas State Laws regarding reporting of child abuse and
Client Signature	Date
Witness Signature	Date 7/2008
	1/2008
Client Name	DOB