CONSENT and ACKNOWLEDGMENTS
EFFINGHAM COUNTY HEALTH DEPARTMENT

I, _____do hereby consent to allow the Effingham
(Print Name of Client)
County Health Department and its designated employees to perform a medical evaluation, provide services and treat conditions found therein. I understand the nature and consequences of any procedures to be performed will be explained to me.

☞ I understand that the Health Department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

☞ I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Health Department.

☞ I authorize the release of any medical or other information necessary to process this claim. (I also request payment of government benefits either to myself or to the party who accepts assignments, if applicable.)

☞ I authorize payment of medical benefits to the undersigned provider for services described below if applicable.

_____ _____
**Signed** **Dated**

I hereby authorize the release of medical records to:

_____ _____
Name Relationship

_____ _____
Name Relationship

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FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgment of the Receipt of the notice of Privacy Practices on behalf of the Effingham County Health Department. The Health Department was unable to obtain the Acknowledgment because:

☐ Client refuses to sign

☐ Other (Specify): _____

_____ _____
(Staff Member's Initials) Date

Staff: Place Acknowledgment in patient's medical record or appropriate file.