MOBILE COUNTY HEALTH DEPARTMENT
General Consent Form

NAME	STREET ADDRESS	DATE OF BIRTH
CITY	STATE	ZIP
PATIENT NUMBER	INSURANCE TYPE	POLICY NUMBER

Treatment

I give permission for me or the above named individual to receive healthcare (medical, optometry, dental and mental health) services provided by the Mobile County Health Department. This consent includes healthcare services such as physical and mental health examinations, laboratory tests (including tests for sexually transmitted diseases (STDs) and HIV infection by antibody test, routine immunizations, and other healthcare treatments or preventive healthcare activities, as deemed necessary by clinical healthcare providers and dentists.

I understand that health information concerning me or the above named individual may be released to any healthcare worker within the Mobile County Health Department who is involved with my care or the care of the individual named above. Additionally, if necessary, I authorize the Mobile County Health Department to make referrals, which may contain any and all of my or the above named individual's health information, including but not limited to sexually transmitted diseases, to outside providers in order to aid in the treatment of my or the above named individual's particular health condition or potential health condition.

I understand that if an invasive procedure or a permanent tooth extraction is required as part of my treatment or the treatment of the individual named above that I will be provided an opportunity to sign a separate informed consent form for that particular treatment or test and for no other treatment or test. The informed consent will explain the procedure or test to be performed and the associated benefits and risks.

I understand and agree that, if I invite a family member, friend or other person into the exam room with me, I consent to the sharing of my or the above named individual's protected health information with that family member, friend or other person who is present.

Payment

I authorize the release of any and all relevant health information concerning me or the individual named above to process a claim and request payment from Medicaid, Medicare, other third party insurance carriers, or other guarantors or payers, either to me or to the Mobile County Health Department.

Health Care Operations

I authorize, as needed, the release of my or the above named individual's health information to an outside copying service for photocopying, microfilming, and/or forwarding this health information to third parties.

I also authorize the release of my or the above named individual's health information for routine healthcare operations such as assessing and reviewing the quality of care received and the competency of healthcare professionals working at or on behalf of the Mobile County Health Department.

I understand and have been provided with a copy of the Mobile County Health Department's Notice of Privacy Practices that provides a more complete description of the uses and disclosures of my or the above named individual's health information.

In consideration of the healthcare services being provided to me or the above named individual, I hereby agree to release the Mobile County Health Department, its board members, directors, officers, employees, agents and volunteers from any legal liability for providing me or the above named individual with healthcare services.

I understand that the State of Alabama allows me to consent for treatment if I am 14 years of age or older, and that if I am this age or older and I do not require any other consent, that I am the sole owner of my health information and that I am the only one authorized to release such information.

Signature of Patient, Parent or Legal Representative	Witness
PRINT name of Patient, Parent or Legal Representative	PRINT name of Witness
Date	Date

For Medicaid Patients

A patient signature is required of all Medicaid patients as verification of services rendered on date of claim. This signature must be kept in the patient's health record. Signatures are not required under the following circumstances: (1) When the patient is illiterate; in this case an "X" may be signed by patient in front of a witness that has seen the marking (witness must attest to marking with signature and date); (2) Patient is not competent to sign because of age, mental or physical impairment.