ABCD Family Planning Partnership

Informed Consent for Family Planning Services

Name: _____
Date of Birth:_____
Medical Record Number:_____

1. I voluntarily request family planning services. No one is forcing me to do this.
2. I understand I have the right to consent to or refuse any specific family planning services offered to me.
3. I understand that all of my personal health information will be kept confidential and used only by healthcare providers involved in my care, unless I give permission in writing to share this information or it is required by law. For example, some infectious diseases must be reported to the state department of public health.
4. I understand that I have a right to a copy of my medical records.
5. I understand that it is my responsibility to provide accurate personal health information so that healthcare providers can provide me with appropriate care.
6. I understand that I can get family planning services even if I cannot pay for these services.
7. I understand that I do not have to accept family planning services in order to get any other services at this health center.
8. I understand that the family planning services I am receiving may be funded in part by Action for Boston Community Development (ABCD). I give ABCD permission to review my family planning record if needed to ensure the quality of family planning services. I understand that my name or other personal information will not be used by ABCD except for billing purposes.
9. Any medical treatments, physical exams, procedures, and lab tests included in the family planning services I receive have been explained to me and my questions have been answered to my satisfaction.
10. I received instructions about how to contact the health center if I have questions, concerns or an emergency.
11. I gave a phone number (confidential if necessary) where I can be reached in case of an emergency.

If I am under 18 years old:

12. I discussed whether I want to involve a family member in my decision to receive family planning services. I understand that I may ask for and receive family planning services confidentially, without the permission or notification of a parent, guardian, or other family member.
13. I understand that information about my family planning visit may be shared without my permission if I am or may be abused or neglected, if I might harm myself or someone else, or if my life is in danger.

I understand the above consent form and have been given the opportunity to ask questions.

_____

Signature of Client Date

_____

Signature of Interpreter (If needed) Date

_____

Signature and Title of Provider Date