

**REQUEST FOR SURGERY OR SPECIAL PROCEDURE AND ACKNOWLEDGEMENT
OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

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.

Procedure/Service

I have been given information about the test(s), treatments, service(s)/procedure(s)/surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I was given *written patient information* and/or a copy of the Planned Parenthood Client Information for Informed Consent sheet. It was reviewed with me.

I understand that with any service/procedure/surgery, there is also the possibility of side effects. 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 about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

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 have been told how to get care in case of an emergency.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorized Planned Parenthood staff to do whatever is necessary to preserve my health and welfare.

In the event I need more pain medication to safely continue or complete the procedure, I request and authorize Planned Parenthood staff to give me medications they believe necessary. This may include medications to reduce pain and/or anxiety. I understand

every medication carries a small risk. I understand the clinician will only use medications if s/he believes it is clinically indicated.

I 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) and perform the service(s)/ procedure(s)/surgery listed above.

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 understand that confidentiality will be maintained as described in [NAME OF AFFILIATE'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 acknowledge receipt of Vermont Women's Choice 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.
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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/his behalf) received the above mentioned information and said she/he read and understood same.

Signature of Witness

Date