Clermont County Public Health Informed Consent for Services

Client Name: _____ DOB: _____ Phone #: _____

Address: _____

General Consent for Services
I voluntarily consent to receive services from Clermont County Public Health (CCPH). I acknowledge that these services are voluntary and are provided to support the health and well-being of myself and/or my child, and that I may withdraw my consent at any time. These services may include, but are not limited to, assessment, examination, education, counseling, immunizations, laboratory testing, medication administration, prescription-related services, case management, home visits, breastfeeding consultation, and other public health services provided by CCPH. I understand that breastfeeding support provided by WIC Health Professional(s) and/or a WIC Breastfeeding Peer Helper may include consultation, assessment, physical evaluation, and observation as appropriate to support maternal and infant health. By sharing my email and mobile phone number, I agree to receive periodic text messages and emails related to the services received.

Telehealth Services Consent
I understand that CCPH may provide services using telehealth technologies, including video, audio, and electronic communication. Telehealth services may be used for consultation, education, monitoring, and other public health services when appropriate. I understand that telehealth involves certain limitations, including potential technical difficulties or interruptions, and that telehealth may not be appropriate for all situations. I understand that I may decline telehealth services at any time and request in-person services when available. Telehealth sessions are conducted in compliance with HIPAA; however, CCPH is not responsible for confidentiality breaches caused by individuals present at my location.

Risks and Benefits
I understand that there are potential benefits and risks associated with receiving public health services, including telehealth services. CCPH staff have explained the nature of services, expected benefits, and possible risks to me in a way I understand. I understand some services are individually based and informed by shared clinical decision-making, a decision process between my provider and me. I have had the opportunity to ask questions and receive answers.

Privacy and Confidentiality
I understand that my health information will be kept confidential in accordance with federal and state laws, including HIPAA. I authorize CCPH to use and disclose my health, social, and financial information as necessary for treatment, payment, healthcare operations, and coordination of services. I understand that I may request a copy of CCPH's Notice of Privacy Practices at any time.

Payment and Insurance
I authorize CCPH to bill applicable insurance programs or funding sources for services provided. I certify that the information I provide for payment purposes is accurate. I understand that I may be responsible for services not covered by insurance or funding programs and can receive text messages with a link to access my account online, which allows me to view and pay for balances I am responsible for.

Rights, Responsibilities, and Complaints
I acknowledge that I have been informed of my rights and responsibilities as a client of CCPH. I understand how to file a complaint or grievance regarding services received without fear of retaliation.

Voluntary Participation and Withdrawal of Consent
I understand that my participation in services is voluntary. The consent provided in this form will remain in effect and be maintained in the client's record unless and until it is revoked in writing by the client or their legally authorized representative, except where services are required by law. I understand that refusal to provide consent or withdrawal of consent may affect my ability to receive certain services. For some programs or services, consent may be required to be renewed annually or at other specified intervals in accordance with program requirements, applicable laws, or agency policies.

Acknowledgment and Signature

_____ I acknowledge that I have received or have access to the Clermont County Public Health Notice of Privacy Practices.

I have read, or had read to me, the information above. I understand the information and agree to the services described.

Client or Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If Client is Unable to Sign

Client unable to sign because: _____

Name of Client Representative: _____

Relationship to Client: _____

Authority of Representative (parent, guardian, DPOA, etc.): _____

Signature of Representative: _____ Date: _____

Witness Signature: _____ Date: _____