The Door – A Center of Alternatives, Inc.
Adolescent Health Center

GENERAL CONSENT FORM

Name: _____ **Date of Birth:** _____

I consent to the provision of medical, dental, eye care, nutrition, dermatology, linkage and navigation services and mental health services given to me by the Adolescent Health Center, which may include physical examinations, vaccines, comprehensive evaluations, screenings and testing, diagnoses, and/or treatment.

I understand that I am receiving services on a voluntary basis, and that family planning services are not required in order for me to receive other services offered at the Adolescent Health Center.

I understand that all information will be kept confidential, except as required by law, or a consent is signed by me which allows the health center to release my records. Family participation in the decision to seek family planning services was discussed with me and encouraged.

I understand that the Adolescent Health Center will respect my chosen methods of communication except when it may be necessary to contact me urgently because of a serious healthcare concern.

I acknowledge that I have been given a copy of the Adolescent Health Center's **"*Patient Bill of Rights and Responsibility*"** information.

If 18 years of age or older, I have been offered information on Advance Directives and informed that I may request a copy of the **"*New York State Health Care Proxy*"**.

I have read and understand the above information and have been given the opportunity to ask questions. This consent will remain in effect unless and until I cancel it in writing.

Patient Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____