



San Antonio Metropolitan Health District
General Consent and Disclosure

The information in this consent form is given so that you will be informed about the health care services you will receive. If you understand the information and agree to receive the service, sign this form to indicate your consent.

NOTIFICATION: The San Antonio Metropolitan Health District (SAMHD) encourages individuals to seek a personal physician/dentist or community medical/dental clinic for examinations and treatment of health/dental problems. The SAMHD clinic services are targeted toward prevention of health/dental problems among those who cannot access a physician/dentist. The SAMHD cannot assume the responsibility of payment if medical/dental care received outside this clinic.

DISCLAIMER ON SCREENING: The SAMHD performs screening tests, which may identify individuals who are at risk for developing common medical/dental problems which may require medical/dental evaluation and treatment from a private physician/dentist, community medical/dental clinic or Emergency room. Screening tests do not cover all diseases/conditions and are not a diagnostic. They may not identify all the diseases they are intended to find and do not replace or constitute a complete examination. I understand that no warranty or guarantee has been made to me by the SAMHD regarding test results.

GENERAL CONSENT: I give permission to the SAMHD, its designated staff and other medical/dental personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give medications, and render, dental and medical health services to the patient identified on this form. This consent will be in effect unless canceled by me in writing.

PRIVACY NOTIFICATION: With a few exceptions you have the right to request and be informed about information that the SAMHD collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the SAMHD to correct any information that is determined to be incorrect. You may permit or restrict the release of this information. I have received a copy of the SAMHD's HIPPA privacy notification dated 4/14/03 which further explains how medical information may be used and disclosed.

I certify this form has been fully explained to me and I understand its contents. I have been given an opportunity to ask questions about the services and risks and benefits and all my questions have been answered to my satisfaction.

Patient's Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Signature of Person Authorized to Consent (if not patient) \_\_\_\_\_s

Relationship \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

TO BE USED IF PATIENT IS UNABLE TO READ OR WRITE

I, \_\_\_\_\_, although unable to read or write, have had the above form read and fully explained to me and my questions have been answered to my satisfaction. I give my consent and request to have these services rendered to me.

Patient's Mark (X) \_\_\_\_\_ Date \_\_\_\_\_

Witness #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness #2 Signature \_\_\_\_\_ Date \_\_\_\_\_