DUPAGE COUNTY HEALTH DEPARTMENT
111 North County Farm Road, Wheaton, Illinois 60187
(630) 682-7400
www.dupagehealth.org

Client Name:	ID:	Date:

Privacy Notice Acknowledgement

I understand and agree that the DuPage County Health Department may use and/or disclose my protected health information for reasons outlined in the Notice of Privacy Practices. The reasons for the use and/or disclosure of my protected health information may include, but may not be limited to, my treatment, payment for my treatment or for health care operations. I understand that, as applicable, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Illinois AIDS Confidentiality Act, the Illinois Sexually Transmissible Disease Control Act, the Federal Substance Use Confidentiality Regulations (42 CFR Part 2) and other privacy provisions provide additional requirements for the use and/or disclosure of my protected health information and may require additional authorization.

Authorization of Assignment of Benefits

I request that the payment of applicable benefits be made to the DuPage County Health Department on my behalf and hereby authorize such payment for services provided by the DuPage County Health Department and/or its agents or designees.

Consent for Treatment

I authorize any testing and/or treatment which the DuPage County Health Department, through its medical professionals, determines may be necessary or beneficial for my health. I understand that the results of any such testing and/or treatment cannot be guaranteed. I understand that I have the right to refuse any testing and/or treatment to the extent permitted by applicable law. I understand that health care personnel in training and under supervision may be observing and/or participating in any testing and/or treatment which the DuPage County Health Department, through its medical professionals, determines may be necessary or beneficial for my health and I agree to such observation and/or participation. I understand, as applicable, all of the risks and costs involved in the treatment, including the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment.

☐ I do not consent to HIV Testing (opt-out)

I have read this consent form and/or have had this consent form explained to me and I understand its contents. I hereby agree to all the terms and conditions set forth above**.**

☐ **Client** ☐ **Parent** ☐ **Guardian**

Signature	Printed Name	Date
Name		
Witness		

If acknowledgement not obtained, check one of the following reasons:

☐ Client emergency situation - will attempt later

☐ Treatment required by law

☐ Substantial communication barrier

☐ Anonymous Testing

Attempt made on (date) _____/_____/_____ at (location) _____.

Explanation of above (nature of emergency/law requiring disclosure/communication barrier): _____

Staff Signature	Printed Name	Date

Copy to Human Resources Attention: Privacy Officer