STICKNEY PUBLIC HEALTH DISTRICT

CONSENT and ACKNOWLEDGMENT
Receipt of Joint Notice of Privacy Practices

I, ___________________________________ do hereby consent to allow the Stickney Public Health District and its designated employees and contractors to perform a Podiatry/medical evaluation and treat conditions found therein. I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the health department dated January 1, 2017.

____
Signed

____
Date

____
Parent/Guardian

____
Date

Check if any of the following apply:

☐	Parent or Guardian of minor	☐	Health Care Surrogate
☐	Power of Attorney for Health Care	☐	Mental Health Treatment Preference Declaration Agent
☐	Guardian with power to make health care decisions		

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the HD. The HD was unable to obtain the Acknowledgment because:

☐ Client refuses to sign ☐ Other (specify): ____

____________________(Staff member's initials) ______________________________(date)