Place patient label here

CONSENT FOR FAMILY PLANNING SERVICES

1. I am voluntarily requesting family planning services from the New Mexico Department of Health, Public Health Office. I understand that I have the right to accept or refuse these services without being denied other services from this agency.
2. I understand that my services and records will be kept confidential and will be released only as permitted or required by law and that my health information will not be released to an outside agency or person except as specified in "Notice of Privacy Practices" which I have received a copy of.
3. I understand that in cases of abuse or neglect of minors by parent(s)/guardian(s)/custodian(s) a referral or a report to law enforcement and CYFD will be filed, as required by law.
4. I understand that if my parent(s)/guardian(s)/custodian(s) have failed to protect me from a harmful situation including if my partner is considerably older than me (otherwise known as statutory rape), a referral or a report to CYFD or law enforcement will be filed, as required by law. I understand that I am under no obligation to report the age of my partner(s) if I do not wish to do so.
5. I understand that if I am seen in the clinic and I receive Family Planning services and supplies I may be charged from a sliding fee scale. I will be responsible for these charges if they apply.

Client's Signature:_____ Date:_____

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FAMILY INVOLVEMENT AND COERCION SCREENING IN SERVICES FOR MINOR-AGE CLIENTS (*under 18 years old*)

For Nurse/Clinician Use Only:

____ I have discussed the limitations of confidentiality with this client, including that we have to report to CYFD if we know or have a reasonable suspicion that he/she is being abused or neglected by the parent/guardian/custodian. I explained that a failure to protect from a harmful situation by a parent/guardian/custodian will also need to be reported to CYFD, possibly including statutory rape. The client was informed that he/she is under no legal obligation to report the age of their partner(s). (1-855-333-7233) (Staff may use the confidentiality materials).

____ I have discussed that we encourage family involvement if we find a condition/situation that can harm her/his health and she/he needs help with this.

____ I have screened this client regarding coercion and/or counseled how to resist attempts of being coerced into sexual activities. (Staff may use the sexual coercion brochure.)

_____ _____ _____

Nurse/Clinician Signature Title Date

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The nurse has encouraged me to involve my parent(s)/family in my counseling and decision to receive family planning services. I have considered this and have decided that:

___ The clinic nurse or doctor may answer any inquiries from my parent(s)/legal guardian about my family planning services.

___ I do not want my parent(s) /legal guardian to know about my family planning services.

The plan for contacting me is: (list 2 ways to contact you below.)

Address other than home_____

Phone #_____ Alternate Phone #_____

Only contact me at School_____Current Grade_____

_____ _____ _____

Signature of Minor Client Date of Birth & Age Date