Universal Consent

Champaign Urbana Public Health District

Name _____

ID _____

Birthday _____

Date_____

I acknowledge that I received a copy of the *Joint Notice of Privacy Practices*. This notice contains detailed information about my rights regarding personal and health information and how that information may be used and disclosed by Champaign-Urbana Public Health District (CUPHD).

I authorize CUPHD to provide care to me/my dependent. This authorization covers all medical services rendered, including but not limited to: examinations, laboratory testing, treatment and immunizations. I further understand that the services may include HIV and STD testing, unless I refuse. I acknowledge that I may be surveyed about my mental health needs and alcohol/drug use to assist CUPHD providers in my services.

I understand that CUPHD works collaboratively with teaching institutions, and residents and students may be involved in my services, unless I state otherwise.

I authorize CUPHD to make appropriate referrals for me/my dependent.

I authorize CUPHD to bill my insurance, Medicaid, or other third party payers and I assume full responsibility for the unpaid portion for the cost of my services at CUPHD.

I acknowledge that CUPHD will keep my information confidential and not release it to anyone else without my written permission, unless required by law. Federal and State laws require certain medical conditions be reported without my consent. These conditions may include, but are not limited to: HIV/AIDS, tuberculosis, and certain sexually transmitted diseases.

I hereby consent to receive auto-dialed and/or artificial or pre-recorded message calls and/or text messages to the phone number that I have provided to CUPHD.

I authorize CUPHD to collect information from me/my dependent that may be entered into State and Federal databases, when applicable and necessary. Such databases may include, but are not limited to: The Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE), an immunization record-sharing application that allows public and private providers to share immunization records with other physicians statewide; The Illinois Department of Public Health (IDPH) Provide® Enterprise for quality assurance review by IDPH and any designated Lead Agency of that region for grant funding the testing activity; and The IDPH HIV Surveillance Unit to release to CUPHD the dates of past HIV diagnosis and treatment to facilitate appropriate support for treatment linkage or reengagement.

I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time.

Champaign-Urbana Public Health District

PLEASE PRINT CLEARLY

DATE OF BIRTH: / /	**AGE:**
LAST NAME:	**FIRST NAME:**
MAILING ADDRESS:	**CITY:**
STATE: **ZIP CODE:**	**EMAIL:**
HOME PHONE: ( )	**CELL PHONE:** ( )
INSURANCE: BCBS Health Alliance Medicaid Medicare United Health Care Other_____	
GENDER: Man Woman Transman Transwoman Transgender Non-Binary Non-Conforming Agender Fluid	
RACE: *Please circle* Black/African American White Asian Alaskan Native Native American Pacific Islander Native Hawaiian Don't Know Other_____	
ETHNICITY: Hispanic / Latino Non-Hispanic / Latino	**ARE YOU A/AN:** Student Employee Dependent

FOR OFFICE USE ONLY

	YES	NO	DON'T KNOW
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?			
5. Is this the first time the person will be receiving the flu shot?			

Place Sticker Here

Nurse Signature:_____