General Consent for Medical Treatment/

Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: ____

DOB: ____

SSN (optional): ____

<u>Consent for Medical Treatment</u>

I, the client identified below or the client's legally authorized representative, voluntarily consent to medical treatment and diagnostic procedures provided by the Center for Black Women's Wellness and its associated physicians, clinicians, and other personnel. I consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I understand that the discovery of certain medical conditions, such as HIV, venereal disease and certain other conditions specified by law, may require the Center for Black Women's Wellness to disclose certain information to the Georgia Department of Community Health or another state health agency. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations.

____ ______________________

Signature of Client or Client's Representative Date

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Representative's Relationship to Client

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received and have been given the opportunity to read a copy of the Center for Black Women's Wellness, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Soletchi Sery-Seya, Wellness Program Manager at 477 Windsor St. Ste. 309 Atlanta, GA 30312; tel: (404)688-9202.

____ _______________________

Signature of Client or Client's Representative Date

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Representative's Relationship to Client

☐ Client/Representative Refuses to Acknowledge Receipt: (Please Check)

____ _______________________

Signature of Staff Member Date

Revised 9/15/14