Oswego County Opportunities, Inc.

FULTON · OSWEGO · MEXICO · SUNY OSWEGO · PULASKI

Patient Name:____ DOB:____________________

Informed Consent for Family Planning Services

I give permission to Oswego County Opportunities, Inc. (OCO) to examine, perform laboratory tests and to prescribe treatment and medication as indicated. I understand the examination may include a pelvic exam, breast exam, Pap smear, testing for sexually transmitted diseases, pregnancy testing, blood pressure, weight, hemoglobin and urine check.

I understand that I have a right to confidential individual health care and that all my records and information will be kept in the strictest of confidence. If I am under age 18, I also understand that OCO would like me to inform my parents about the family planning services provided to me, and would assist me in doing this. However, I understand that it is my decision whether my parents should be informed and this decision will not affect the services that I can receive.

I understand that I have the right to receive a printed copy of the Patients' Bill of Rights. I also understand that a printed copy is posted in the waiting and exam rooms of The Center. If I prefer I may access a copy at **https://www.health.ny.gov/publications/1515/**.

I understand that services are provided on a voluntary basis and my acceptance of family planning services is not a prerequisite to eligibility or receipt of any other service offered by OCO.

Should any testing for sexually transmitted diseases (such as chlamydia, gonorrhea or HIV) come back positive, I understand that a report must be filed with the New York State Health Department and a representative will contact me in a confidential manner requesting that I name my sexual contacts so that they may be treated.

____ ____________________________
Patient Signature Date

____ ____________________________
Witness Signature Date

Consent to Participate in NYSIIS

I give consent to Oswego County Opportunities Center for Reproductive Health to release my immunizations to New York State Immunization Information System (NYSIIS).

I understand that the purpose of NYSIIS is to assist in my medical care by recording the Immunizations I have received or will receive in the future.

This information may be released to myself, my health insurance plan, state and local health departments, schools I am registered to attend, and medical providers that deliver my medical care.

____ ____________________________
Patient Signature Date