MIDLAND COUNTY DEPARTMENT OF PUBLIC HEALTH

Legal Name: _____

Date of Birth: _____

Midland County Health Department, its employees or agents may provide applicable services, examination and/or diagnostic testing or treatment. These services are provided confidentially, on a voluntary basis, without my being forced to accept any services or medications.

I understand that information from my record may be shared with the members of my treatment team. My treatment team will be determined by the services I receive, and may include, but is not limited to, a nurse, nurse practitioner, primary care provider, social worker, dietician and Michigan Department of Health and Human Services. In the event of an infestation or infection of a school-aged child, my child's school may be contacted. Childhood immunizations may be shared with the Michigan Childhood Immunization Registry. Any other release of information will require a specific release, signed by the client, custodial parent or guardian, unless the information is otherwise legally required.

Midland County Health Department may release, either verbally or in writing, information contained in my medical, social, or educational records, including HIV, AIDS, or AIDS related information, as is necessary for the authorization and payment of bills for professional services.

I understand that I am responsible for charges due the Health Department **(clinic services only)**. All services billed to a private insurance plan **(clinic services only)** will create an explanation of benefits that will be sent to subscriber of the insurance plan.

I hereby authorize all responsible parties to pay directly to the provider and Midland County Health Department all benefits and amount due for services rendered by the physician. All payments will be made to provider and practice at Midland County Health Department.

If a Health Department employee is exposed to blood or body fluids by puncture, or consent to open skin or mucus membrane, the client's blood may be tested for HIV and other infectious diseases without further consent.

As a partner in my health care, I understand that participation and follow through is expected. Services may be terminated due to noncompliance.

I consent to and agree that Midland County Health Department (MCHD) may request, access, and receive my medication history data from SureScripts Inc., a prescription system that allows prescriptions and related information to be exchanged between MCHD's electronic medical record (Patagonia) and your pharmacy/pharmacies.

The terms and consequences of this assignment and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely.

This authorization will continue in effect through the duration of service associated with this admission or condition, up to one year, or until revoked in writing.

06/10/2025