COOK COUNTY HEALTH

COOK COUNTY HEALTH AT CERMAK HEALTH SERVICES OF COOK COUNTY

Name: DOB: Sex: M / F CCDOC#

GENERAL CONSENT FOR HEALTH SCREENING, DIAGNOSIS AND TREATMENT

I. CONSENT FOR DIAGNOSIS CARE AND TREATMENT

I consent to a medical, dental, and mental health history and physical, including screening for tuberculosis and sexually transmitted infections, and other infectious diseases by Cermak Health Services as a part of Cook County Health ("CCH") during the routine intake process at Cook County Jail.

I also consent to ongoing medical treatment by CCH staff for health issues, infectious disease management, and preventative care needs identified during this process. I understand I may be asked to sign forms allowing other medical treatments.

I am aware that one or more physicians, residents, nurses, physician assistants, psychologists, dentists, and other health care providers may attend to my medical, dental, and mental health needs as necessary. I am further aware and consent that, among those who care for me, are other health care providers in training who care for patients at CCH as part of their education.

I acknowledge that no guarantees have been made to me as to the result of any diagnosis, treatment, test, surgery, or examination performed by CCH.

II. SHARING OF HEALTH INFORMATION/CONTINUITY OF CARE

I understand that my minimally necessary medical information may be shared with Cook County Jail staff as necessary for the safety and management of the Cook County Jail detainees as permitted by law.

III. OPT-OUT FOR TESTING

I understand that HIV is serious, and I accept the risk of not knowing if I have it. HIV testing is voluntary, and I may withdraw consent to the testing process at any time. If I refuse to have HIV testing performed, I will still receive other services for which I am eligible. The confidentiality of my test results will be maintained except as provided under the law and in this consent.

I understand I have received information about screening tests for HIV, Syphilis, Chlamydia, Gonorrhea, and Hepatitis. I understand that I will be tested unless I refuse.

☐ **I refuse to consent to following opt-out screening test(s)** ☐ HIV ☐ Hepatitis ☐ Syphilis ☐ Chlamydia/Gonorrhea

IV. APPLICATION FOR MEDICAL BENEFITS

I consent for CCH to act as my agent to make an application in my name for public medical benefits, including to complete, sign, and submit an application or redeterminations for benefits or to pursue appeals and to receive and submit information about the application, redetermination, or appeals on my behalf. I understand that I have the right to revoke my consent, in writing, at any time if I no longer wish to have CCH apply for medical benefits on my behalf or by checking the box below:

☐ **I do not consent or revoke my consent to allow CCH to apply for public medical benefits on my behalf as of the following date of this General Consent.**

_____ _____ Date:____/____/____ Time:____AM/PM

Signature of Patient

_____ Date:____/____/____ Time:____AM/PM

Witness Signature

COOK COUNTY HEALTH

COOK COUNTY HEALTH AT CERMAK HEALTH SERVICES OF COOK COUNTY

Name: DOB: Sex: M / F CCDOC#

GENERAL CONSENT FOR HEALTH SCREENING, DIAGNOSIS AND TREATMENT

REMOTE INTERPRETER (Section must be completed if patient's preferred language is not English)

Remote Interpreter [Interpreter ID]: ___ Company _____

A remote interpreter translated this consent form into _____, the preferred language for medical communication of the Patient.

Signature _____ Date: _____ Time: AM PM

☐ **Provider obtaining consent is bilingual in the patient's preferred language** ___ ___ ___ _____
(Provider signature)