Consent for Service

Name_____ **Date of Birth**_____
Printed Name of Client

I, the undersigned, give my consent for the services that I am requesting from the Oklahoma State Department of Health and its entities/contractors. I understand that the risks and benefits for these services will be explained to me and that I will have the opportunity to ask questions.

I also understand that

- The information regarding myself and the services I receive will be entered into OSDH management information systems and may be used for program evaluation, management and billing purposes. However, my name will not be released without my written permission;
- I will not be denied service because of my inability to pay;
- I may refuse service at any time.

I acknowledge that I have received a copy of the Oklahoma State Department of Health Privacy Notice as required by the Health Insurance Portability and Accountability Act.

☐ Self
☐ Other (Specify)

_____ _____
Printed Name of Consenter Relationship to Client

_____ _____
Signature of Consenter Date

_____ _____
Additional Signature (if required) Date