**Sexually Transmitted Disease (STD) Testing Consent and Release Form**

I understand that:

* CompassCare provides free reproductive health medical services for men and women, including STD testing, diagnosis and treatment, pregnancy testing, and ultrasound exams for confirmation of pregnancy. **CompassCare does not provide general medical care or emergency services. If you have pelvic pain, abnormal bleeding or a fever, you should go to the emergency room immediately.**
* I have requested the services of a volunteerphysicianthrough CompassCare for the purpose of STD testing, diagnosis and treatment. My appointment today with a Registered Nurse will be limited to initial diagnosis and, if necessary, treatment of some STDs. Those STDs not diagnosed and treated today will be addressed during my follow-up results appointment.
* **Any recent exposure I may have had to a STD may not be evident in my test today, but I may still be able to pass it on to a partner. Any exposure following this appointment also puts me at risk for acquiring a STD.**
* CompassCare does not prescribe birth control, nor does CompassCare give out information for the purpose of obtaining birth control.
* A referral list with the names of local doctors, including gynecologists, is available for my use. I acknowledge that it is my responsibility to obtain follow up for my ongoing health care.
* **New York State Law requires that certain positive STD test results be reported to my County Health Department, including HIV, Hepatitis, Syphilis, Gonorrhea and Chlamydia.**
* **I am responsible for receiving the results of my tests, in person. Results will never be given to me over the phone.** I must return for a follow-up appointment with the nurse, within approximately two weeks. If I do not return within 2 weeks, I agree to be contacted at the number below by a nurse for the purpose of scheduling a results appointment. I also give my permission for CompassCare to send a certified letter to my home address if I can not be reached at the phone number provided.
* In order to effectively provide for my medical care, staff of CompassCare will have access to my confidential records. My records will not be released to any agency or individual without my written permission except as required by law.
* **The reproductive health screening that I receive today does not include, among other things, testing for Human Papilloma Virus (HPV) or a PAP test. I must obtain those tests through my own physician.**
* **By signing below, I am giving permission for CompassCare to perform, as necessary, a urine pregnancy test, blood draw and a physical exam including obtaining swabs for purpose of STD testing.**
* **A chaperone is available to me during the physical exam if I wish to have a third person present, and I may initial below to request that chaperone**. If I do not initial the line below, I am giving my consent to have that physical exam done with only the Registered Nurse performing my exam present.

Patient requests chaperone: ­­­\_\_\_\_\_\_\_\_\_\_\_

I hereby give full consent to these medical services and I waive and release any and all claims whatsoever kind and nature that I, my legal representatives or heirs and relatives might have or hereafter have against CompassCare, its physicians, medical personnel, directors, officers, employees and volunteers. I expressly agree that this waiver, release and indemnity agreement, is intended to be as broad and inclusive as permitted by the laws of this state, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

I have read and understand the above information,

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| --- | --- |
| Print Name |  |
| Patient Signature |  |
| Date |  |