

**GREEN HILLS COMMUNITY ACTION AGENCY/WOMEN'S HEALTH SERVICES
1506 OKLAHOMA AVENUE/P.O. BOX 278
TRENTON, MO 64683 (660) 359-2855**

MALE INFORMED REQUEST AND CONSENT FOR TREATMENT

I hereby request that a person authorized by this agency examine and treat me as appropriate. I understand that the examination process may include a review of my medical history, education and the testing of sexually transmitted diseases, examination and education in the testes self-exam technique, height, weight, blood pressure, and review of other systems.

I authorize the customary medical procedures, which may include screening for anemia, diabetes, hypertension, sexually transmitted disease, and cancer.

I agree to accept responsibility for any additional and/or follow-up care that may not be available at this clinic.

I understand that:

- All procedures are associated with certain risks. No guarantee or assurance has been made to me as to the results.
- I have the right to refuse any procedure or medical treatment.
- All procedures including nature and purpose, other methods of treatment, risks involved, and possibility of complications will be fully explained to me.
- If test(s) performed for sexually transmitted diseases are positive, state law requires that the results be reported to the State Department of Health.
- My records will be kept in the strictest of confidence. My records may be inspected at this site by the Missouri Family Health Council and/or the Missouri Department of Health for the purpose of reviewing charges, services and quality of care provided to me, however these representatives will maintain the highest level of confidentiality. Information from my medical record may be used for statistical purpose; however my identity will be protected. Information from all my medical records will not be released to anyone else without my consent.

YEAR ONE

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

YEAR TWO

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

YEAR THREE

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

YEAR FOUR

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____