

## Maternal and Child Health Services

### **Consent for Services**

Maternal and Child Health (MCH) and Public Health Nursing (PHN) provide a variety of home and community based services to support families. The maternal child health programs offer home visits starting before the birth of the baby and may continue through childhood. The purpose of these visits is to strengthen families, connect clients with community services, and offer guidance regarding child care and development.

**I consent for myself, and my child if indicated, to participate in the maternal child programs offered through MCH and PHN.** I understand that participation in these services is voluntary and that I may withdraw at any time without any affect on me or other services I may be receiving. Potential benefits of the service have been explained to me.

### **Confidentiality**

I understand that confidential records may be kept containing personal information about me and my family. Confidential information is sent to the Wyoming Department of Health (WDH) MCH Unit for the purpose of data collection, analysis, and program evaluation in order to improve services to Wyoming families.

All confidential information is protected according to Federal and State law. MCH and PHN are bound by state reporting statutes relating to child protection.

### **Acknowledgement of Receipt of Notice of Privacy Practices**

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.

I, \_\_\_\_\_ (client's name), have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

### **Release to Share Information**

I hereby authorize the following persons and/or agencies to engage in verbal or written communication for me or my child. Pertinent records and information can be shared between MCH/PHN and agencies identified below as necessary for comprehensive assessment, monitoring of services and care coordination. I am aware that this information will be used in the best interest of me and/or my child in order to provide the best medical and case management services. I am aware that I may deny consent for disclosure to any of the agencies/providers designated below.

The agencies authorized for MCH/PHN to exchange information include:

\_\_\_\_\_ Physician \_\_\_\_\_

\_\_\_\_\_ Physician \_\_\_\_\_

\_\_\_\_\_ WIC \_\_\_\_\_

\_\_\_\_\_ Child Development Center \_\_\_\_\_

\_\_\_\_\_ School \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

*This consent/release is valid for one (1) year while receiving these services. A photocopy or reproduction of this authorization is as valid as the original.*

**Client as a Minor**

If the client is a minor, the client’s parent or guardian must sign. If minor reports that she is emancipated she may initial on the appropriate line below and sign for services:

A minor may consent to health care treatment to the same extent as if he/she were an adult when (Wyoming State Statute 14-1-101):

\_\_\_\_\_ The minor is or was legally married.

\_\_\_\_\_ The minor is in the active military service of the United States.

\_\_\_\_\_ The parents or guardian of the minor cannot with reasonable diligence be located and the minor’s need for health care treatment is sufficiently urgent to require immediate attention.

\_\_\_\_\_ The minor is living apart from his/her parents or guardian and is managing his/her own affairs regardless of his/her source of income.

\_\_\_\_\_ The minor has received a declaration of emancipation pursuant to W.S. 14-1-203.

\_\_\_\_\_ (Print) Mother (client): First Last Maiden name      Child: First Last

\_\_\_\_\_ Client/or parent/guardian: **Signature**      \_\_\_\_\_ Date

\_\_\_\_\_ Witness      \_\_\_\_\_ Date