

NASHUA AREA HEALTH CENTER
A CENTER OF LAMPREY HEALTH
10 PROSPECT STREET, SUITE 102 ~ NASHUA, N.H. 03060
603.883.1626

CONSENT FORM

Patient's Name: _____

Patient's Date of Birth: _____

I voluntarily request this agency to provide me with contraceptive information, medical services, STD/HIV testing, and the method of my choice, barring medical contradictions, to avoid an unplanned pregnancy.

I understand the importance of my personal safety and the need to give my consent in all sexual relationships. I realize this means it is my decision to be in a relationship. I realize this means it is my decision to be in a relationship where I am not forced into any activity against my will.

I have been encouraged by this agency to involve my parent(s) or guardian(s) in this decision.

Please check one: I have involved him/her/them
 I have not involved him/her/them

The information in this medical record is confidential and is protected under the laws of NH. I understand that this record and my test results will be released to the NH Division of Public Health Services. I also understand that my test results shall not be released to any other person or agency, without written permission from me.

I request and give my consent to a physical examination. I understand that I will be examined by a medical practitioner and I may be requested to provide bodily specimens to determine if I have a sexually-transmitted disease.

Patient's Signature

Date

Witness

Date