**FAIRFAX COUNTY HEALTH DEPARTMENT – STD SERVICE SLIP**

**CLIENT NAME:** _____ **DOB:** ____/____/____ **PIN:** _____

**SECTION BELOW TO BE COMPLETED BY CLIENT:**

**RECORD KEEPING**

I understand that medical records will be retained for five years after the event. In the case of a minor, the record will be retained 21 years after birth.

**PATIENT CONSENT FOR GENERAL PRIMARY CARE**

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers of the Fairfax County Health Department (FCHD) to examine and/or treat me and/or my dependent, as named above.

**DOCUMENTATION OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received the Notice of Privacy Practices from the Fairfax County Health Department.

**NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING**

FCHD is required by § 32.1-45 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any FCHD health care professional, worker or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to the blood or body fluids of a FCHD health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

**HIV TESTING**

If HIV testing is performed, you will be told ahead of time, be given information about the test, and allowed to decline testing. All results will remain confidential except as allowed by law.

I understand that this consent will remain in effect as long as my dependent or I receive care from FCHD or until I withdraw it.

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis — Date Signed

_____ _____

Relationship (if signature is not of Patient) — Signature of Person Obtaining Consent

**COMMONWEALTH OF VIRGINIA**
**VOTER REGISTRATION AGENCY CERTIFICATION**

**If you are not registered to vote where you live now, would like to apply to register to vote here today? (Please check only one)**

☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
☐ No, I do not want to register to vote.

_____ _____ _____

Applicant Name — Signature — Date

**SECTION BELOW TO BE COMPLETED BY HEALTH DEPARTMENT STAFF ONLY:**

| START TIME | PROVIDER | FINISH TIME | SERVICE TIME | CPT CODES (Check CPT CODE for service provided) | SERVICES |
|---|---|---|---|---|---|
| _____ | _____ Provider Signature | _____ | _____ (In Minutes) | ☐ STDTEST | STD TESTING |
| | | | | ☐ STDTX | STD TREATMENT |
| | | | | ☐ COU | COUNSELING - STD |
| | | | | ☐ 86703 | HIV TESTING ONLY |
| | | | | ☐ 81025 | PREGNANCY TEST FP/MAT |
| _____ | _____ Provider Signature | _____ | _____ (In Minutes) | ☐ STDTEST | STD TESTING |
| | | | | ☐ STDTX | STD TREATMENT |
| | | | | ☐ COU | COUNSELING - STD |
| | | | | ☐ 86703 | HIV TESTING ONLY |
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| | | | | ☐ STDTX | STD TREATMENT |
| | | | | ☐ COU | COUNSELING - STD |
| | | | | ☐ 86703 | HIV TESTING ONLY |
| | | | | ☐ 81025 | PREGNANCY TEST FP/MAT |

**Date of Service:** _____ **Check out Time:**_____