FOR OFFICE USE ONLY

Insurance Type:

☐ Medicaid ☐ Medicaid/Medicare
☐ Medicaid+Private ☐ Medicaid+Spenddown
☐ Private ☐ No Insurance

Guardian: ☐ Yes ☐ No

☐ **Phone Consent Obtained**

Approved: **Insurance Verification Needed:**

_____ _____
Initials Initials

St. Clair County Community Mental Health

Informed Consent for Blood Draw

Name: _____ Case #: _____

I consent for myself, or the person I am legally responsible for, to the drawing of a blood sample for the purpose of medical treatment.

I understand the risks involved with blood draws include, but are not limited to, discomfort at the site of the blood draw, possible bruising, redness and swelling around the site, bleeding at the sight, feeling lightheadedness when blood is being drawn, and rarely, an infection at the site of the blood draw.

I understand and accept that data derived from this blood draw is considered preliminary only and does not constitute any kind of diagnosis. It is my responsibility for initiating a follow-up examination to confirm results and obtain professional advice and medical treatment.

I understand if a CMH staff sustains an exposure to my blood or body fluid that HIV, HCV, and HBV tests may be performed on me without my consent and the results shared with that CMH Staff.

St. Clair County Community Mental Health will keep my results confidential and will only release information to other organizations with my consent.

This consent is valid for 12 months. At any time you have the right to withdraw this consent.

Individual Print: _____ Date: _____

Individual Signature: _____ Date: _____

Parent/Guardian Signature (If applicable): _____

I understand that I am responsible for any cost not covered by my insurance for this blood draw, and that I will receive a bill from Lake Huron Medical Center for any non-covered cost.

Individual Signature: _____ Date: _____

Parent/Guardian Signature (If applicable): _____

Verbal Consent Obtained:

Staff Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This section is to be completed for HIV/Hepatitis blood draws only

I understand if I have a current PCP who I have seen in the last 6 months, I have the option for my blood to be tested for HIV/AIDS and/or Hepatitis and the results shared with my PCP.

☐ I consent to testing for HIV and Hepatitis and the results to be shared with my PCP.*

☐ I **DO NOT** want my blood to be tested for HIV and Hepatitis.

* I authorize St. Clair County Community Mental Health to discuss my test results and follow up care with the St. Clair County Health Department in the event that I test positive for HIV and/or Hepatitis.

Health-Medical Form: #04-0381
Reviewed Date: 11/1/2024
Policy Ref: #04-002-0040
EHR: Legal/Consent, Other Legal Documents Note: Informed Consent for Blood Draw