Maternal Child Health of SW Iowa
Child Health Services
Consent Form

Client Name:	Date of Birth:
Address:	Phone:
Title XIX #:	

I, _____ give Taylor County Public Health
Parent/guardian/ or client — name of agency

consent to provide my child with Child Health Services by a Registered Nurse, Social Worker, or other qualified staff.

Child Health Services may include the following: *Initial next to each service:*

____ Education/Anticipatory Guidance
____ Assistance Getting a Doctor or Dentist
____ Assistance Getting Insurance
____ Assistance Linking to Community Resources
____ Assistance Getting Transportation
____ Assistance Getting Interpreter Services
____ Referral and other care coordination services
____ Capillary blood draws and lead poisoning prevention education
____ Immunizations
____ Developmental screenings

- A copy of the agencies Notice of Privacy Practices was made available to me on _____. *(insert date)*
- I understand that these services are provided through the Iowa Department of Public Health, Maternal and Child Health Program.
- I understand that records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health (Bureau of Family Health or Bureau of Oral and Health Delivery Systems), Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.
- Medicaid will be billed for eligible services.
- Fee may be charged for those over 200% of poverty.

in household _____
monthly income if not on Medicaid $_____
fee for Service $_____

This consent for services is valid for one year unless withdrawn in writing by parent, or guardian, or client (if of legal age).

_____ _____
Signature of Parent, Guardian, or Client (if of legal age) **Date**