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Champaign-Urbana Public Health District

Maternal and Child Health (MCH) Privacy Policies and Agreement

Client Name: ____ **Birthdate:** ________________________

Parent/Guardian: ______________________________________

While enrolled in the Champaign-Urbana Public Health District (CUPHD) MCH programs including WIC, Better Birth Outcomes, and APORS, I give permission to CUPHD and its employees to provide the following services in each section by writing my initials in each section I am agreeing to. I also understand that these services are voluntary and are not required to participate in WIC. Refusal to consent to any/all the below sections will not affect WIC eligibility.

_____ I give permission to CUPHD to provide services to me/my child and to release information to my health care provider(s). I understand that it is my responsibility to seek further medical attention when advised or if I have additional concerns about my health or child's health. I accept full responsibility for my care and treatment and release CUPHD and staff of all liability for any adverse results that may occur due to my refusal to seek recommended medical evaluation and treatment.

_____ I give my consent to the CUPHD and its employees to perform laboratory (including Hemoglobin- no charge for WIC program), physical, developmental and social emotional screenings, assessments, and tests required to determine the general health of myself or my child while enrolled in the WIC and/or Better Birth Outcomes programs.

_____ I authorize payment of insurance benefits to CUPHD for medical professional services including breastfeeding support services as well as Developmental Screenings, Perinatal Depression and Post-Partum Depression Screenings (used for Better Birth Outcomes and APORS programs).

_____ I also understand that it may be necessary to release this information to other providers that also provide care or to other agencies that may need to be referred to. Example: Physician, Mental Health Services, Early Intervention Services, schools, etc. The information disclosed may include matters regarding mental health, developmental disability, alcohol and/or drug abuse, reproductive health information, sexual assault, adult disabilities, sexually transmitted diseases, infectious diseases including HIV/AIDS, etc. Refusal to consent to the release of information will result in such confidential records not being released.

_____ The information that is disclosed in the Privacy Policy is acknowledged by me and I have also been offered a written copy of the Privacy Policy as well as given a verbal explanation of the Privacy Policy.

_____ I have read and understood the above terms of this Authorization and I hereby knowingly and voluntarily authorize CUPHD, including WIC and Better Birth Outcomes, to use or disclose my health information in the manner described above.

_____ I consent to receiving **emails** from CUPHD.

My email address is: ______________________________________

_____ I consent to receiving **text messages** from CUPHD.

My cell phone number is: ______________________________________

____ __________________________

Signature of Patient/Parent/Guardian Date

____ __________________________

Witness Date

This institution is an equal opportunity provider.

MCH Consent for Services last updated: April 2025