



**General Consent Form**

I voluntarily consent for myself or my minor child to receive medical examinations, treatments and procedures which are deemed necessary by the physician or other healthcare providers at Orange County Health Department (OCHD). I also consent to treatment and care by physicians and health care providers who are not employees of OCHD such as resident physicians, students or other trainees who are authorized by OCHD to provide treatment and care to me as a patient of OCHD.

I hereby acknowledge that I received or have been given the opportunity to review a copy of the OCHD's Notice of Privacy Practices. I understand that state and federal laws permit certain uses and disclosure of my health information for treatment, payment and other healthcare operations without my consent. I understand that I may contact the department's Privacy Officer if I have a complaint, questions or concerns.

***I understand this consent is valid for the period of time needed to fulfill its purpose for up to one year. I understand I may revoke this consent at any time and that I will be asked to sign the Revocation Section of this form.***

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
OCHD Staff Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter's Signature (if necessary)

\_\_\_\_\_  
Date

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**Revocation Section**

I, \_\_\_\_\_ do hereby revoke the above consent.  
(Print name)

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
OCHD Staff Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter's Signature (if necessary)

\_\_\_\_\_  
Date