CONSENT FOR PREGNANCY TESTING

Name ______________________________ Birth date ______________ Age ______

I hereby request the Portsmouth City Health Department Family Planning Clinic to test my urine for pregnancy. I understand that the earlier the test, the greater the chance of error, and that the test results should be confirmed by physical examination. I further understand that the correctness of the results of the urine test is not guaranteed whether positive or negative.

Requesting a less sensitive urine pregnancy test, I understand that I should have a pelvic examination within 10 days of the test if I am considering abortion or within 30 days of the test if I am considering prenatal care. If any problems should arise, I should contact a physician or the emergency room immediately.

I hereby release the Portsmouth City Health Department Family Planning Clinic and its medical staff and employees from any and all liability arising out of or connected with this pregnancy test, and particularly with regard to any errors in diagnosis based on this test.

Patient signature ______________________________ Date ______________

Counselor's signature ______________________________ Date ______________

I authorize and grant permission to the Portsmouth City Health Department Family Planning Clinic to release, provide, and admonish to my physician or CAO Clinic information and records concerning my pregnancy test results.

Patient signature ______________________________ Date ______________

Counselor's signature ______________________________ Date ______________