

FAMILY REPRODUCTIVE HEALTH SERVICES

Chadron, Alliance, Crawford, Gordon, Rushville, Chadron Native American Center

Chart Number: _____

By signing this release, I _____, authorize/ approve
Client's printed name

_____/ _____ as a proxy to pick
Printed name of proxy / relationship to client

up my contraceptives for me in situations where I'm unable to get to the Western

Community Health Resources (WCHR) office.



I understand that to protect my confidentiality that my proxy needs to know my ID number and be able to provide that number to staff before my files will be accessed and/or contraceptives are provided to my proxy. _____

I understand I am still obligated to pay and therefore my proxy is obligated to pay for any contraceptives picked up for me. If I am on donation scale, the proxy will be asked if she/her can donate for the contraceptives. _____

I understand that this form will be maintained indefinitely in my chart and it is my responsibility to contact this office and inform staff of any changes with regards to whom I allow or do not allow as a proxy. I understand that if my proxy is changed, I may request a new ID number to enforce confidentiality. _____

Client Signature: _____

Date: _____

Staff Signature: _____

Date: _____