Livingston County Public Health Department

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Public Health
Prevent. Promote. Protect.

CORNERSTONE CONSENT FORM

Name of Participant:_____
(LEGAL) (Last) (First) (M)
Date of Birth:_____ Female _____ Male _____
(Month) (Day) (Year)

It is important that you read the following. If there is anything that you do not understand or if you have any questions be sure to ASK.

Welcome to cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; and Healthy Families Illinois and IBCCP.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Department of Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professions with a direct need to know about you will have access to the computer. Information may be released for audit and evaluation purposes. *Necessary information without any client's name, will be sent to federal agencies that fund these programs.*

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

A. I authorize ***LIVINGSTON COUNTY PUBLIC HEALTH DEPARTMENT*** (Cornerstone Site) to collect information during the enrollment/registration process.
B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical history, prenatal, birth and postpartum data; infant/child visit data; immunization records; participant risks,; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program. Any information you do not want released should be written in Part D.
C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.
D. The following is information I do not want to be shared: _____
_____
E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Department of Public Health liable for the release of any information about me in accordance with the terms of this consent form.
F. A photostatic copy/facsimile of this consent will be as valid as the original.
G. I give permission for my child to be screened for Hg/Hct and/or lead. (Applicable ONLY if here for WIC).
H. I give permission to release medical information to medical/social service agencies. I also give my consent to release immunizations, hemoglobin and lead results to the schools, Head Start and my daycare provider.

For child participant: For adult participant:

_____ OR _____

(Signature of parent/legal guardian/caretaker)

DATE_____