HEALTH CENTER

Name: _____ Student ID# _____

I consent to services furnished at Darton State College Student Health Center staff. I hereby request that a person authorized by Darton State College Health Center (DSCHC) perform examination and/or tests on me and provide appropriate treatment when indicated.

The nature and purpose of the procedures and treatment have been explained to me. I understand that a clinician is available to answer any questions I may have.

I consent to the use or disclosure of my protected health information by the Darton State College Student Health Center for treatment, payment, and health care operations. I realize that if tests are taken for sexually transmitted diseases, reporting of certain positive results to public health agencies is required by law.

I assume full responsibility for and agree to pay for all services rendered or o be rendered.

I understand that medical records are kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Family Rights and Privacy Act (FERPA). I acknowledge that the Notices of Privacy Practices are posted at the Student Health Center and a copy provided to me upon request.

I understand that my medical record are confidential and that information will only be released upon my written consent. This excludes information necessary for statistical, licensure, funding and /or billing purposes for which I give permission to the employees of DSCHC (and others authorized by them) to use, with the understanding that my confidentiality will be maintained.

Referral will be made for further diagnosis and/or treatment when indicated.

I understand that if follow-up is needed, I will assume responsibility.

I hereby grant Darton State College Health Center permission to treat and/or make necessary referrals for medical/psychological care, if needed. I understand that my medical records are kept **confidential** in accordance with the Health Insurance Portability and Accountability Act (HIPPA) privacy practices. I have received an overview the Darton State College Student Health Center's Notice of Privacy Practices. I understand I may request a copy of the Policy in its entirety at any time. I also understand there is a copy of said Policy posted in the Student Health Center for my review.

Parental or custodial consent is required for all minors under 18

Patient Signature: _____ Date: _____

Parent Signature (if required): _____