

CONSENT FOR MEDICAL TREATMENT AND USES AND DISCLOSURES OF  
PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT AND  
HEALTHCARE OPERATIONS (TPO) AT THE STUDENT HEALTH CENTER

Please read, complete and sign the back of this consent form.

I give my permission to the Student Health Center (“Provider”) and its employees, volunteers, agents and independent contractors to educate, interview, examine, perform laboratory procedures and to treat my condition, as they deem necessary. I understand that in case of a life-threatening emergency, this consent may be implied for the time of the emergency.

I understand that the Student Health Center is a teaching institution, therefore medical residents, medical students, dental students, nurse practitioner students and nursing students may participate in my care under the supervision of a physician/dentist or nurse practitioner. I understand that other outside medical professionals may also be consulted as deemed necessary for my care.

For coordination of my care and services, I understand that I may be provided with referrals to off campus specialists and the Student Health Center may assist other treating physicians/dentists in provision of my care.

- **Informed Consent:** If my condition requires an outpatient surgical procedure, the practitioner responsible for my care will explain to me the procedure to be performed, the general nature and extent of risks involved in such procedure and the alternative methods, if any.
- **Consent for Minor Students:** If you are a minor, we must have the signature of the parent or legal guardian (appointed by a court of law) on this form before any general treatment may begin, and such consent must be effective until you reach legal age in the State of Nevada (18 years old). Your parent or legal guardian must sign this consent form and receive a Notice of Privacy.
  - ◆ **Exemptions to this consent are** a life-threatening emergency, treatment for emancipated minors with court supporting documents and per **NRS 442.255** and **NRS 129.060** for family planning and contraceptive methods, screening for sexually transmitted infections, counseling and treatment of alcohol and substance abuse.

I understand and agree that the Student Health Center may use or disclose protected health information for treatment, payment and operations in accordance with the Notice of Privacy Practices that I have received, and any posted amendments to that Notice. I understand that the Student Health Center will not use or disclose protected health information for any purpose other than as allowed in the Notice of Privacy Practices, unless such use or disclosure is authorized by law or I have provided a written authorization. (**See full explanation of disclosures and rights in the Notice of Privacy Practices**) If I am being treated while I am a student, I consent and agree that my health information may be used and disclosed in accordance with the Notice of Privacy Practices (and any posted revision of that Notice) and the federal Health Insurance Portability and Accountability Act of 1996.

In the process of receiving health care at the Student Health Center, the Student Health Center may initiate a follow up call and a letter may be sent to continue care. Also, patients may receive phone calls to remind them of a scheduled appointment.

◀ **Please turn page for additional uses and disclosures of health information** ▶

I understand that if I agree to participate in a research study, I will be provided with a specific authorization to participate. (**See Notice of Privacy Practices**). I have the option to choose not to participate or to withdraw from the study at any time.

I understand that I have the right to revoke this consent in writing, unless the Student Health Center has already used or disclosed my information in reliance on the consent.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information to carry out treatment, payment, or healthcare operations and that the Student Health Center is not required to agree to the restrictions requested.

Please note: I understand that if I request a restriction that may impede the ability of the Student Health Center to provide proper care, or which restricts the release of information required by law to be released, that the Student Health Center is unlikely to agree to the restriction and may cancel further services. Further, I understand that if I request a restriction that does not allow the Student Health Center to release necessary information to insurance providers; it may affect my ability to obtain reimbursement for medical expenses.

I acknowledge receipt of a copy of the Notice of Privacy Practices, effective April 14, 2003, which contains a more complete description of uses and disclosure of patient health information.

I understand that the Student Health Center reserves the right to change the Notice of Privacy Practices and a revised copy will be posted and available when requested. The changes will be applied to all prior and subsequent health information.

**Patient Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**If patient is a minor:**

Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Description of Legal Guardianship: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone No. : \_\_\_\_\_