## GENERAL CONSENT FOR TREATMENT

## Patient Authorization for the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operation

I, (PATIENT NAME) request and authorize medical care at Southern University Student Health Center as my physician, nurse practitioner or physician assistant may deem necessary or advisable. This care may include, but not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, and routine medical and nursing care. I authorize the Southern University Student Health Center to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my provider(s) and that other personnel render care and services to me according to the provider(s) instructions.

- I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures. I authorize the Southern University Student Health Center to disposes of the bodily fluids.
- I have been informed and understand that an HIV test may be performed on me without my consent if deemed necessary by a provider or if a health professional or employee or First Responder sustains an exposure to my blood or other body fluid.
- I have been informed that COVID-19 and other viral or bacterial illnesses pose a significant risk to patients and staff. Infection control measures are in place for the protection of you, other patients, and our staff as part of our commitment to your health, safety, and well-being. Nevertheless, in-facility (office/clinic/face-to face) medical treatment presents an unavoidable risk of exposure to illnesses that must be minimized to the extent possible by social distancing (when possible), wearing masks, frequent hand washing, and any other available safety measures. My signature below acknowledges and consents for treatment and the risks of COVID-19 or other viral or bacterial exposures through a face-to-face/in-facility treatment
- I have been informed that the Student Health Center provides direct referrals to the University Counseling Center concerning any patient deemed necessary by the SHC provider with or without the consent of the patient to ensure the physical and mental well being of the patient and safety of the campus community.

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

The Southern University Student Health Center Notice of Privacy Practices provides information about how protected health information about me(the patient) - including information about human immunodeficiency virus (HIV), AIDS-related complex (ATC) and acquired immunodeficiency (AIDS); including substance abuse treatment records protected under the regulation 42 part 2, in the Code of Federal Regulations (if any); and psychological and social services records, including communication made to me to a social worker or psychologist (if any) may be disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and I may obtain a revised copy by contacting the Southern University Student Health Center.

- I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or healthcare operations. My provider(s) are not required to agree to this restriction, but if they agree, will be bound by the agreement.
- By signing this form, I acknowledge that I have been offered and/or received the Southern University Student Health Center Notice of Privacy Practices.

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

I understand that as part of my healthcare, the Southern University Student Health Center, originates, maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that my medication history and formulary benefits may be downloaded from a secure electronic clearinghouse. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among the many healthcare professionals who contribute to my care
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals

**I acknowledge that a copy of Notice of Privacy Policy was provided to me. I understand that I have the following rights and privileges:**

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that the Southern University Student Health Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Southern University Student Health Center reserves the right to change its notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation. Should the Southern University Student Health Center change its notice, it will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, via email).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I understand and acknowledged that I received a Notice of Privacy Practices, and I consent to such disclosures as delineated in the Notice.

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

<Patient Signature>

<Current Date>