UChicago Student Wellness

CONSENT FOR MEDICAL TREATMENT OF MINORS

Name of Minor: Birthdate (MM/DD/YYYY):
Name of Parent/Guardian:
Address of Parent Guardian:

Telephone of Parent/Guardian:

Welcome to UChicago Student Wellness. We will make every effort to be sensitive to students' needs and assist in addressing students' concerns. In order to help your child/dependent, we believe it is important for you to understand our policies. Please read the items listed and sign this form below to acknowledge your awareness. In addition, if your child/dependent is 13 or older, you should discuss the listed items with them, and they should also sign this form. Thank you.

AUTHORIZATION FOR TREATMENT

I hereby voluntarily consent for my child/dependent to receive such diagnostic and therapeutic procedures, including University and State of Illinois required immunizations/vaccinations, as may be ordered or deemed advisable by the University's authorized provider or their designee. This consent does not cover invasive or surgical procedures.

COMMITMENT TO CONFIDENTIALITY

Please be assured that medical care and counseling at UChicago Student Wellness are confidential. Health care records are completely separate from all other University records. Student Wellness staff members consult with one another as needed to provide coordinated and collaborative care; in the event your child/dependent is treated at UChicago Medicine or another affiliated hospital, UChicago Medicine and UChicago Student Wellness may share relevant health information for continuity of care. Otherwise, UChicago Student Wellness will not release any information about your child/dependent without your written permission, except as authorized or required by law, including as necessary to protect your child/dependent or others from a serious threat to health or safety. UChicago Student Wellness clinicians are required to follow the mandated reporter child abuse recognition and reporting law. The Abused and Neglected Child Reporting Act requires a clinician to report child abuse suspicions to the authority or government agency vested to conduct child abuse investigations.

AUTHORIZATION TO RECORD AND USE HEALTH INFORMATION

I understand that UChicago Student Wellness uses an electronic health record system, will keep records concerning my child's/dependent's medical and/or mental health care in electronic or other form, and will use electronic means of communication between clinicians and with students.

I consent to UChicago Student Wellness sharing my child's/dependent's information with other UCM and non-UCM health care providers through electronic portals and exchange, for the purpose of coordinating medical care. I understand that this would enable other providers to access certain information in my child's/dependent's medical record at UChicago Student Wellness, including – if applicable – information relating to mental health, HIV/AIDs, genetic testing, Communicable Diseases (STIs), in-vitro fertilization, abuse, domestic violence, and drug and alcohol treatment information. I know that this process is voluntary and that I may "Opt-Out" at any time by requesting an "Opt- Out" form.

Clinicians may consult with supervisors or colleagues to improve their own skills and to provide the highest quality services possible.

- If a clinician is being supervised, the patient will be informed of the name of the supervisor upon request.
- A patient's clinical encounters will never be video or audio recorded without the patient's (or, if applicable, the patient's parent/guardian) prior written consent.
- UChicago Student Wellness compiles statistics on its health and mental health services activities. From time to time, UChicago Student Wellness staff make presentations and write articles as part of their work in an academic setting. In no event will personally identifiable information be disclosed in such cases.

I understand that I am not required to waive rights under any regulations, including, to the extent applicable, the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA), as a condition of the provision of treatment or payment for health care services to my child/dependent. For more information about how UChicago Student Wellness uses and discloses health information, please refer to UChicago Student Wellness's Notice of Privacy Practices, which can be found at https://wellness.uchicago.edu/notices.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION FOR BILLING PURPOSES

I understand that my UChicago Student Wellness clinicians may order laboratory tests (e.g. bloodwork), diagnostic imaging (e.g., X-rays, CT scans), or other services that are not covered by the Student Services Fee. I understand that it may be necessary for UChicago Student Wellness to collect and share my child's/dependent's health insurance information with the providers of those services. I hereby assign insurance benefits; direct and authorize UChicago Student Wellness to release to my child's/dependent's insurance carrier(s) or other payors or third parties such diagnostic and therapeutic information as may be necessary to determine benefits entitlement and to process and to collect payment. I understand that I may be liable for any services not paid/covered by my child's/dependent's insurance payer. I further consent to receive auto-dialed and/or pre-recorded calls to my child's/dependent's cell phone number provided during the registration process, by UChicago Student Wellness or UChicago Medicine and their affiliates and agents, including account management companies and debt collectors.

Please note that mental health services offered by UChicago Student Wellness are covered by the Student Services Fee.

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE:

ACKNOWLEDGED BY CHILD/DEPENDENT
IF 13 YEARS OF AGE OR OLDER: _____ DATE:

Signature on this consent form is required on an annual basis.