THE UNIVERSITY OF TEXAS AT DALLAS
STUDENT HEALTH SERVICE

CONSENT FOR TREATMENT OF A MINOR WHO DOES NOT HAVE LEGAL POWER TO CONSENT

With few exceptions, you are entitled on your request to be informed about the information U.T. Dallas collects about you. Under Sections 552.021 and 522.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have U.T. Dallas correct information about you that is held by us and that is incorrect.

NAME_____ ID#_____

ADDRESS_____BIRTHDATE_____

CITY, STATE_____ZIP_____

1. AUTHORIZATION FOR EXAMINATION AND TREATMENT:

The undersigned has been informed that examination procedures, vaccines, and/or treatment considered necessary for the patient named on this record will be performed by the Nurse Practitioner, Consulting Physician, or other employees of the UTD Student Health Service (AKA Student Health Center). Authorization is hereby given for such treatments and procedures and the administration of such local anesthetics, medications, or other treatment deemed necessary. I certify that I have read the above authorization, and understand the same and also certify that no guarantee or assurance has been made as to the results that may be obtained. The Nurse Practitioners, Consulting Physician, appropriate staff and The University of Texas at Dallas and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

2. ACKNOWLEDGEMENT OF OUTPATIENT TREATMENT:

I hereby understand and agree that the medical care, which may be furnished to me in the UTD Student Health Service, will be limited solely to outpatient treatment. I understand and agree that I may be released before all my medical problems are known or treated and that it will be necessary for me to make arrangements for follow-up care.

3. RELEASE OF INFORMATION:

I hereby consent to the release of my medical information to authorized UTD Student Health Service staff, Counseling Center staff, and consulting physicians, including those seen in the Health Center and/or those seen on a referral basis from the Health Center, also including hospital Emergency Rooms and medical personnel with ambulance services.

4. ACKNOWLEDGEMENT OF REFERRAL SERVICES:

I hereby understand and agree that medical care and/or treatment deemed necessary for the undersigned may involve referral to specialty physicians, Emergency Rooms, X-ray facilities, or other providers outside the UTD Health Center, and that any and all expenses for referral services are the responsibility of the patient.

5. CONSENT TO PERMIT TESTING AFTER AN OCCURRENCE OF A BLOOD OR BODY FLUID EXCHANGE:

In the course of care and treatment within the UTD Health Center, health care workers may be accidentally exposed to a patient's blood or body fluids (through needle sticks, blood splatters, etc.). Communicable diseases, including the HIV virus that causes AIDS, are known to be transmitted through accidental exposures of this type. When a health care worker is exposed to a patient's blood or body fluid, the patient may be required to be tested for HIV antibody and other communicable diseases in order to determine whether an actual exposure has occurred. This information is necessary so that the health care worker can receive appropriate counseling and medical treatment. I understand and agree, that in the event a health care worker is exposed to my blood or body fluids, my blood will be tested, at no cost to me, in a confidential manner, for HIV antibody, and other communicable diseases. The results of these tests will not prejudice my patient relationship in the Student Health Center.

6. ACKNOWLEDGE BEING INFORMED ABOUT THE NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have been informed about the NOTICE OF PRIVACY PRACTICES of the UTD Student Health Service. This information describes how my medical information may be used and disclosed and how I may have access to the information. HIPAA Privacy Rules require that we furnish you with the notice.

_____ _____ _____

Signature of Parent/Authorized Person | Relationship | Date

_____

Print Name of Parent/Authorized Person

_____ _____

Signature of Witness | Date