The University Of
TAMPA
DICKEY HEALTH AND WELLNESS CENTER

Minor Medical Treatment Consent-For students Under 18 Only

PATIENT NAME: First and Last **Student ID#:** **DOB:** Month/Day/Year **AGE:**

TELEPHONE#: **Emergency Contact Name:** **Emergency Contact Ph#:**

I hereby authorize The University of Tampa Dickey Health and Wellness Center to employ diagnostic procedures and to render any treatment or medical care, including, but not limited to, arranging for and/or authorizing consultation, evaluation, treatment, including medication and/or vaccine administration deemed necessary to the health and well-being of my child.

I grant permission for the transfer of my child to an accredited hospital or other health care facility if deemed necessary by the medical provider.

RELEASE OF MEDICAL INFORMATION

I authorize the University of Tampa to release any and all information, including but not limited to copies of medical records in electronic or paper form, to any person or entity for the purposes of treatment, health care operations, and payment, including releasing information to agents or employees of my insurance company or other payers. I specifically authorize the release of information pertaining to any psychiatric care and treatment (but not "psychotherapy notes" as that term is defined by law), mental health care and treatment, HIV serology results, alcohol treatment, and substance abuse care and treatment pertaining to me. I consent to the transfer of electronic data between University of Tampa and its business partners, vendors and other health care facilities for the continuity of care and outpatient services. For a more detailed description of uses and disclosures for treatment, payment or normal healthcare operations, please review the Facility's Notice of Privacy Practices.

I consent to the sharing of my medical records with The University of Tampa Counseling Services' providers, and I consent to the sharing of my counseling records with The University of Tampa Medical Services' providers for the purposes of coordination of care and holistic treatment. I understand that providers for The University of Tampa Medical and Counseling Services will access my records for the sole purpose of coordination of care.

PAYMENT AGREEMENT

By signing below, either as patient or guarantor, I understand and agree that all charges on this visit are due and payable at time of discharge. In the event there may be any third party source(s) for payment including but not limited to insurance, I understand and agree that I am nevertheless responsible for the full obligation until and unless such third party source(s) accept responsibility and pays according to terms of such source(s) and to the extent allowable by law, I understand and agree that I am personally responsible for such portion. Co-payments not remitted at time of service will be billed to the student's University of Tampa account as a Dickey Health Center charge within two business days of the date of service.

In the event that any third party source(s) rejects payment, on such declination and upon notification by Dickey Health and Wellness Center to me, I understand and agree that I shall be personally responsible for such obligation.

Signature of Parent/Guardian **Relation to Student** **Date:** Month/Day/Year

Printed Name of Parent/Guardian **Date:** Month/Day/Year

----------OFFICE USE ONLY----------

Telephone Consent Given By:

Parent/Guardian Name (Print): **Relationship to Minor:**

Date: **Time:**

Witnesses: (2 Signatures required)

DHWC EMPLOYEE:

Print Name **Signature**

DHWC EMPLOYEE:

Print Name **Signature**

IMPORTANT! KEEP A COPY OF THIS PAGE FOR YOUR RECORDS.

Fax (no cover sheet): (813) 258-7413

OR mail this completed form to: UT Dickey Health and Wellness Center, 401 W. Kennedy Blvd. Tampa, FL 33606