KENT STATE UNIVERSITY | University Health Services

Patient Consent for Treatment and Use and Disclosure of Protected Health Information

I consent to the examinations, tests and treatments which may be done by my clinician(s) and health center staff during my visits. I understand I have the right to discuss and ask questions about my treatment.

In case of emergency, I authorize the Director of University Health Services or the medical staff to notify my emergency contact.

I hereby give my consent for **University Health Services** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by **University Health Services** describes such uses and disclosures more completely.

I have reviewed the Notice of Privacy Practices prior to signing this consent. **University Health Services** reserves the right to revise its Notice of Privacy Practices at any time.

I understand that all fees incurred for services at University Health Services are my responsibility. University Health Services will bill most major medical plans. Kent State University sponsors a student health insurance plan which is recommended for all students without adequate insurance coverage. An itemized accounting statement is available by request to all patients visiting the Health Center.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **University Health Services** may decline to provide treatment to me.

Best Phone Number to contact me: __________________________

University Health Services may leave a message on voice mail? Please circle YES or NO

University Health Services uses email for appointment reminders and patient feedback surveys. May we use your email for other communications? YES or NO email address: ____________________

________________________________	______________________
Printed Name	**Date of Birth**
________________________________	______________________
Signature of Patient	**Date**
_____________________________	____________________
Signature of parent/guardian (if student is under 18 years of age)	**Date**

Parent Signature is <u>MANDATORY</u> if the patient is under 18. The patient <u>may not</u> be treated without parent's signature.

NPP Ack/Consent
Revised 7/17 DKR