SHS
UC SAN DIEGO

Patient label

CONSENT FOR MEDICAL TREATMENT/BEHAVIORAL HEALTH SERVICES

Medical Consent: I am voluntarily seeking health care and hereby consent to medical treatment, procedures, x-ray, laboratory tests, and other health care services from UCSD Student Health Services (SHS) and/or other contracted providers. I have the right to refuse specific treatments or procedures. I am at least 18 years of age, an emancipated minor, or the parent/legal guardian of a student under 18 years of age. (NOTE: Minors may consent to treatment for certain medical conditions.)
Health Information and Confidentiality: SHS uses the same electronic medical record (EMR) as UC San Diego Health. In effectuating UCSD's responsibility to ensure the health and safety of UCSD students, UCSDH may access your SHS records in the event you seek care at UCSDH. This access is made for the purposes of improved care coordination for UCSD students in compliance with UCSD policy and Federal and California law. There are strict procedures that must be followed in order to access your medical record. The provider must self-identify by user ID and password protected log-in. The information accessed must be limited to minimum necessary information needed for the coordination of care. The activity generates a record which is subject to audit to ensure compliance with applicable policies and laws. Violators are subject to disciplinary action according to UCSDH policy. UCSDH providers will only access your health information if you seek care with UCSD Health.

Behavioral Health Services (BHS) Consent: BHS includes mental health crisis intervention, clinical case management, and care coordination, provided by the UCSD SHS Clinical Social Worker or the CAPS Psychiatrist, Psychologist, or Post-doctoral Resident. The Post-doctoral Resident is supervised by a licensed psychologist and will inform you of the name and contact information for their supervisor who can be contacted through the CAPS central office.
Health Information and Confidentiality: Information disclosed is confidential except in cases of imminent danger to self, others, or a grave disability, or disclosure of abuse of a child or vulnerable adult. I acknowledge that other providers may access or share information within my chart that is applicable and pertinent to facilitate co-treatment and referrals. Access is limited to relevant information for the purpose of collaborative care. There are strict procedures that must be followed in order to access your counseling record. The provider must self-identify by user ID and password protected log-in. The information accessed must be limited to minimum necessary information needed for the coordination of care. The activity generates a record which is subject to audit to ensure compliance with applicable policies and laws. Violators are subject to disciplinary action according to UCSDH policy. If I do not wish my BHS records be shared with other providers, I have the right to inform my CAPS BHS provider so that access to my counseling information can be limited to CAPS, UCSD mental health and Emergency Medicine providers. I acknowledge that there are emotional risks involved in discussing my personal issues and challenges, and I voluntarily accept these risks. Should it be deemed appropriate for me to begin treatment with a CAPS provider, I acknowledge that I will consent to that treatment separately. UCSDH providers will only access your health information if you seek care with UCSD Health.

For students with UCSHIP insurance: I authorize UCSD SHS to bill my Insurance Plan on my behalf for any outside laboratory or other expenses incurred. I accept responsibility for payment for all services not covered by UCSHIP, including any visit fees and pharmacy co pays. These charges may be paid by credit card on the day of service or charged to my university student account.

For students who do not have UCSHIP insurance: I accept responsibility for payment of all expenses incurred from services provided at UCSD SHS. These charges may be paid by credit card on the day of service or charged to my university student account. Charges include, but are not limited to, visit fees, medications, laboratory testing, x-rays, and supplies.

This agreement of "Consent for Medical Treatment/Behavioral Health Services" can be revoked by me at any time by written notification and is valid until revoked.

Print Student Name	Student PID#	Student Signature	Date/time

If Consent for a minor under 18 years of age:

Print Parent/Guardian Name	Parent/Guardian Signature	Date/time

If an interpreter is used: Interpreter ID_____ Date/Time_____

Verbal Consent for a minor under 18 years of age (circle one): Mother Father Legal Guardian		
Name of person contacted:		Phone:
Witness:		
Print Name:	Signature:	Date:
Witness:		
Print Name:	Signature:	Date: