

# Hawkeye Student Health Center PATIENT CONSENT FORM

## AUTHORIZATION OF SERVICES:

I authorize any physician or designated health professional employed by or working in the Hawkeye Student Health Center to provide the medical tests, procedures, and treatments as are necessary or advisable for the medical evaluation and management of the participant's health care. These services are not intended to replace my physician.

## INCOME DECLARATION AND INSURANCE BILLING FOR MEDICAL SERVICES:

I authorize the release of any medical or other information necessary to process all claims. I authorize payment of medical benefits to the Black Hawk County Health Department and/or Allen Health Systems for services/treatment received. I understand that a voluntary declaration of income and number of persons in my family may be necessary to assure that the Federal, State and County funds are directed to those persons least able to secure services from other sources.

**\*Please supply a copy of both front and back of your health insurance card. \***

## INFORMATION EXCHANGE:

Health Center records will not be shared without written consent. Access to records by patients and/or legal guardian will be available within 48 hours, with the exclusion of those records and information covered under Iowa Code.

I authorize the exchange of information pertinent to the continuity of my health care among the service providers **initialed below**.

Initial & Date

\_\_\_\_\_ Hawkeye Student Health Center / Black Hawk County Health Department

\_\_\_\_\_ Allen Women's Health Department

\_\_\_\_\_ Mental Health Services through Hawkeye Student Health Center

\_\_\_\_\_ My Doctor \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

Yes  No I agree to have my health information provided by the Student Health Center providers placed in one common record.

## AUTHORIZATION FOR RECEIPTS OF SERVICES:

- I have been informed, understand, and consent to receive the services offered to me or my student by the Student Health Center.
- I understand that the information from these records may be shared with the Iowa Department of Public Health Family Services Bureau or its designee(s).

### **Specific Authorization for Release of Information Protected by State or Federal Law**

I specifically authorize the release of data and information relating to (check appropriate box):

- 1. Substance Abuse**  
(Alcohol/Drug Abuse)
- 2. Mental Health**  
(Include Psychological Testing)
- 3. HIV Related Information**  
(Aids Related Testing)

This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR P.2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Civil and/or criminal penalties may apply for unauthorized disclosure of alcohol/drug abuse or mental health information.

**X** \_\_\_\_\_  
Signature of Client or Legal Guardian Date

\* In order for this information to be released you must check the appropriate box(es) and sign above and below.

Please Print

I, \_\_\_\_\_, **Patient or Legal Guardian** agree to the above and allow myself or this student to receive services as indicated below. (This consent is valid for one year from date below, and may be revoked by patient or legal guardian at any time.) In the state of Iowa, the age of consent is 18 years of age for medical treatment.

**Family Doctor/Clinic Name** \_\_\_\_\_

## APPROVAL AND CONSENT FOR TREATMENT AND RELEASE

I have reviewed the above information and believe it to be accurate. I, the undersigned, authorize and consent to treatment. I understand that I may withdraw my consent at anytime. I have received a copy of the Notices of Privacy Practices. Should I be under eighteen years of age, my parent's (or guardian's) signature below indicates approval and consent for medical treatment at the Student Health Center.

\_\_\_\_\_  
Signature of Patient / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Evening Phone

\_\_\_\_\_  
Address & City

\_\_\_\_\_  
Zip Code

By signing this I have read and understand the above statements and services available to the participant. If you have any questions, please give us a call at 296-4224.

HEALTH CENTER STAFF/ Verification Date \_\_\_\_\_

Signature of Health Center Member \_\_\_\_\_

A photocopy or facsimile of this authorization shall have the same force and effect as the original.

Revised 11/06