



Hawkeye Student Health Clinic
Health Education Services Center
PO BOX 8015
1501 East Orange Road
Waterloo, IA 50704-8015

Phone (319)296-4224
Fax (319)296-4270

PATIENT CONSENT FORM

Authorization of services:

◆ I authorize any physician or designated health professional employed by or working in the Hawkeye Student Health Clinic 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 your physician or dentist.

Income declaration & 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.

Information exchange:

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

By signing below:

◆ I authorize the Exchange of Information with my doctor and dentist as listed below whenever necessary for my care.
◆ I have been informed, understand, and consent to receive the services offered to me or my child by the Student Health Clinic.
◆ 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).
◆ I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.

Please bring your insurance card to your appointment.

- I authorize the exchange of information pertinent to the continuity of my health care among the service providers listed below. **Please date and initial next to the provider.**



- _____ Hawkeye Student Health – Family Nurse Practitioner / Black Hawk County Health Department
- _____ Allen Women's Health Department - Family Planning Services
- _____ Mental Health Services / Black Hawk Grundy Mental Health Center
- _____ My Doctor _____
- _____ Other _____

Yes No I agree to have my health information supplied by one or more providers in the Student Health Clinic filed in one common record.



Please Print

I, _____ Patient, 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 in writing at any time. In the state of Iowa, the age of consent is 18 years of age for medical/mental health treatment.

Signature of Patient _____ Today's Date _____ Phone Number _____

Address, City, State _____ Zip Code _____ Date of Birth _____

By signing this I have read and understand the above statements and services available to the participant. By signing this, I acknowledge that I have received, reviewed, and understand the Student Health Clinic Privacy Practices. If you have any questions, please call 319-296-4224. A photocopy for facsimile of the authorization shall have the same force and effect as the original. A copy of this consent can be made available upon request.

**IOWA CODE: Under the Iowa State Code 125.140.9, and Case Law: Carey vs. Population Services International, a minor had the same capacity as an adult to consent to certain health services without parental permission. These include substance abuse services, sexually transmitted disease counseling or treatment, and family planning services.*

HAWKEYE STUDENT HEALTH CLINIC.... *For a healthy mind and body....*