

University of Miami Student Health Service
Consent for Medical Treatment – Minor

COMPLETE AND SUBMIT ONLY IF YOU ARE A MINOR UNDER THE AGE OF 18

Patient Name: _____

Student Number: _____ Date of Birth: _____

1. CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby consent to any and all diagnostic procedures, tests, medical treatment, and hospital care required in the diagnosis of my illness and course of treatment by the physician or his/her designee, medical staff and other agents, and/or employees of the University of Miami Student Health Service, University of Miami and/or University of Miami Medical Group (UMMG) (collectively, the “University”), including supervised residents and medical students. I recognize that the University of Miami is a teaching and research facility and that my treatment and care will be observed and in some instances aided by residents or medical students in their course of training. Additionally, I consent to the use of my medical data and non-identifiable photographs for educational and research purposes. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

2. RELEASE OF MEDICAL INFORMATION (Third Party Payers, Guarantors, Physicians)

By signing this form, I hereby authorize the University to use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the health care operations of the provider treating me; including to the Hospital, Physician or other Provider, Guarantor, of my accounts, or third party payors for which I have assigned benefits for my treatment and care, and, if requested, to my referring physician, or any other healthcare provider responsible for my care. This includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS or HIV diagnosis, testing and/or treatment for this period of illness as well as medical and other information as necessary for the operations of the Hospital or Physician or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition.

3. RELEASE OF LIABILITY FOR LOSS OF PERSONAL PROPERTY

I release the University and the facilities in which services are rendered from liability resulting from the loss by theft or negligence of any employee of the institution or of any third party. I agree that I am responsible for any item(s) I keep with me in my possession, including, but not limited to electronic equipment, money, eyeglasses, jewelry or any other personal items.

4. HEALTH AND COUNSELING CENTERS

I understand that my medical records are confidential except when release is authorized by me or required by law. I understand that if I threaten to harm myself, and/or others, the University may be obligated to seek my hospitalization and/or disclose information contained in my medical records. I also authorize the staff at the University of Miami Student Health Service to discuss my case and treatment amongst themselves and to consult the staff at the University of Miami Counseling Center to coordinate care and/or treatment when professionally appropriate and/or medically necessary.

If a patient is under 18 years of age and is not legally emancipated, s/he should be aware that the law in most cases allows parents to examine their child’s treatment records, unless the physician believes that such a review would be harmful to the client and to his or her treatment.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

Signature of Parent or Legal Guardian _____ Date: _____

Relation to Student: _____

Home Phone # _____ Work # _____ Cell # _____