University of Connecticut Student Health Services

CONSENT FOR TREATMENT

Student's Full Name:_____

Student's Date of Birth:_____ Student ID#:_____

I hereby grant permission for the University of Connecticut Student Health Services staff to provide me with appropriate medical and mental health treatment including medications for treatment of illnesses/injuries and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions.

I understand that SHS may disclose information from my medical records to appropriate University personnel and/or family members and/or my Emergency Contacts in the case of a health or safety situation as deemed necessary by SHS staff.

Further, I understand that Student Health Services staff may disclose my medical records and/or information from such records to appropriate University personnel for purposes of treatment, payment and healthcare operations, and hereby consent to all such disclosures.

Signature of Student (required): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

REQUIRED FOR STUDENTS UNDER 18 YEARS OF AGE

Parent/Guardian Printed Name: _____ Phone:_____

Return completed form to:

UConn Student Health Services
Medical Records Dept
234 Glenbrook Rd U-4011
Storrs, CT 06269-4011
Fax: 860-486-5300
Email: shs@uconn.edu