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: __________

Parent/Guardian Printed Name: ________________________________ Phone: ______________

Consent to Text Messaging:
By initialing, I consent to receive text messages from UConn Student Health Services at my cell phone number above (and any number/e-mail forwarded or transferred to/from that number.) This may include confirmation of an appointment, test results, or a reminder alert. I understand that this permission will remain in effect unless I request a change in writing.

X ________________ Date: __________
Student Initial

Please scan and upload completed form to: Myhealth.uconn.edu
(Log-in with Net-id and Password)