MIDDLE GEORGIA STATE UNIVERSITY HEALTH CLINIC

CONSENT FOR TREATMENT

PATIENT NAME: _____ DATE of BIRTH: _____

MGA ID NUMBER: _____

CONSENT FOR TREATMENT

I hereby consent to receive medical care (or for my minor child or ward under 18 years of age to receive medical care) from Middle Georgia State University nursing staff at the Health Clinic in accordance with the standards of reasonable practice and after being informed of the associated risks and benefits. I also authorize such treatment and other diagnostic studies (Lab) as may reasonably be necessary to preserve and protect my health (or the health of my minor child or ward).

- **RELEASE OF INFORMATION**

I authorize the disclosure of all or part of my medical record to physicians and health care personnel participating in my care and treatment. I also authorize the disclosure of all or part of my medical record to any person or corporation which is authorized to receive this information such as my insurance company, worker's compensation carrier and employer's claim administration. I also authorize the use and disclosure of my protected health information for the purposes of treatment and healthcare operations.

Notice: A student/patient who utilizes the MGA Health Clinic's medical services are expected to visit at times that do not conflict with academic and work responsibilities. In accordance with the MGA attendance policy students are expected to attend all class sessions.

I certify that I have read the above information and agree to the terms and conditions therein. By my signature below I also attest that all statements in the medical and immunization record are true to the best of my knowledge and that I (or for my minor child or ward) have (has) no health problems or medical restrictions not listed on this record.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent (if under 18 years of age) **Date**