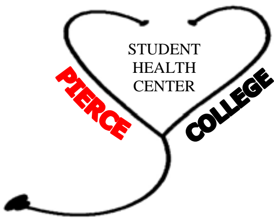

STUDENT HEALTH CENTER
GENERAL ACKNOWLEDGEMENT AND CONSENT

NAME____ID#____________________DATE________________

ADDRESS____

CITY____ZIP____

I hereby request that a person authorized by Pierce College Student Health Center (PCSHC) perform examination and/or tests on me and provide appropriate treatment when indicated.

The nature and purpose of the procedures and treatment have been explained to me. I understand that a clinician is available to answer any questions I may have.

I realize that if tests are taken for sexually transmitted diseases, reporting of certain positive results to public health agencies is required by law.

If I am requesting a laboratory test(s), I release PCSHC and its medical staff and its employees from any and all liability arising out of or connected with this test(s), and particularly with regard to any errors in diagnosis based on this test(s).

I understand that all services provided by PCSHC and my medical record are confidential and that information will only be released upon my written consent. This excludes information necessary for statistical, licensure, funding and/or billing purposes for which I give permission to the employees of PCSHC (and others authorized by them) to use, with the understanding that my confidentiality will be maintained.

Minors
Parental or custodial consent is required for all minors under the age of eighteen before medical treatment or services may be provided, with the following exceptions:

Minors who are at least twelve years of age may consent to the following: emergency treatment; treatment of infectious, contagious or communicable diseases; diagnosis or treatment of rape or sexual assault; mental health treatment and/or counseling; and/or diagnosis or treatment of drug or alcohol related problems. (California Family Code sections 6920-6929)

Parental/Custodial consent is not required for a minor to obtain contraceptives.

Pursuant to American Academy or Pediatrics v. Lungren (16 Cal14th 307 (1997)), parental/custodial consent is not required for a minor to receive an abortion in California.

Referrals will be made for further diagnosis and /or treatment where indicated.
I understand that if follow-up is needed, I will assume responsibility for such follow-up.

CONSENT FOR TREATMENT AND LIMITS OF CONFIDENTIALITY
I hereby grant Pierce College Student Health Center permission to treat and/or make necessary referrals for medical/psychological care, if needed. I understand that my medical records are kept **confidential** in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy practices. I have received and overview the Los Angeles Community College District Student Health Center Notice of Privacy Practices. I understand I may request a copy of the Policy in its entirety at any time. I also understand there is a copy of said Policy posted in the Student Health Center for my review.

Patient Signature ____ Date____________________

Parent/Guardian Signature ______________________________________ Date____________________

Witness*____ Date____________________

Annual Update #1
Patient Signature____ Date____________________

Parent/Guardian Signature ______________________________________ Date____________________

Witness* ____ Date____________________

Annual Update #2
Patient Signature ____ Date____________________

Parent/Guardian Signature ______________________________________ Date____________________

Witness*____ Date____________________

*I witnessed the fact that the patient received and said he/she read and understands the above information.