THE UNIVERSITY OF CHICAGO

Student Health & Counseling Services

Consent for Medical Treatment for Minors

Name of Minor: _____Birthdate (day/month/year): _____/_____/_____

Name of Parent/Guardian:_____
Address of Parent/Guardian: _____
Telephone of Parent/Guardian: _____

AMBULATORY TREATMENT CONSENT

I (We) herby voluntarily consent to such diagnostic and therapeutic procedures as may be ordered or deemed advisable by my authorized provider or his/her designee. This consent does not cover invasive or surgical procedures.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION FOR BILLING PURPOSES

I hereby assign insurance benefits; direct and authorize UCMC to release to my insurance carrier(s) or other payors or third parties such diagnostic and therapeutic information as may be necessary to determine benefits entitlement and to process and to collect payment. I understand that I may be liable for any services not paid/covered by my insurance payer. I further consent to receive auto-dialed and/or pre-recorded calls to my cell phone number provided during the registration process, by UCMC and their affiliates and agents, including account management companies and debt collectors.

I consent to the University of Chicago Medicine sharing my patient information with my other non-UCM health care providers through electronic portals and exchange, for the purpose of coordinating medical care. I understand that this would enable my non-UCM providers to access certain information in my medical record at UCM, including – if applicable – information relating to mental health, HIV/AIDS, genetic testing, Communicable Diseases (STDs), Invitro fertilization, abuse, domestic violence and drug and alcohol treatment information. I know that this process is voluntary and that I may "Opt-Out" at any time by requesting an "Opt-Out" form.

SIGNATURE of Parent or Guardian: _____ DATE:_____

Your health Information that does not identify you may be used for research purposes. Also, you may be asked to participate in research studies at the University of Chicago. Signature on this consent form is required on an annual basis.

Return this form to the Student Health Service via postal mail or hand-delivery by your University of Chicago student.

University of Chicago Student Health Service
5841 S. Maryland Ave, MC3052, R100
Chicago, IL 60637