San Diego City College
Student Health Clinic
GENERAL CONSENT FOR CARE AND TREATMENT

Name: _____

Student ID# _____

1. I am seeking care at the San Diego City College Student Health Clinic (SHC). My signed consent provides the SHC with my permission and authorization to perform reasonable and necessary medical exams, testing, treatment, and emergency assistance as necessary.

2. I acknowledge that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended; and that this consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

3. I understand that I must be a currently enrolled student and attending classes in the San Diego Community College District to receive services from the SHC. I also understand there are limitations to the services provided at the SHC, and that I may be referred to a health care provider or facility in the community if necessary. SHC does not provide healthcare services afterhours, on weekends, or during district holidays/breaks/recesses.

4. I have the right to discuss my treatment plan with my physician, nurse practitioner, or nurse including the purpose, potential risks, and benefits of any test(s) or medication(s) ordered for me. If I have concerns regarding any test or recommended treatment, I am encouraged to ask questions.

5. We understand that your medical information is sensitive and personal. We are committed to protecting your privacy, and will not disclose confidential medical information without your consent unless required to do so by law. The SHC complies with the confidentiality mandates of the Family Educational Rights and Privacy Act (FERPA), and the California Confidentiality of Medical Information Act (CMIA). The SHC also complies with state and federal mandatory reporting requirements for reasons such as disease surveillance, public health activities, abuse or domestic violence, etc. A copy of our **Privacy Policy** is posted in the clinic, and a personal copy is available to you on request.

6. **The SHC works as part of a professional team that includes the Mental Health Counseling Center (MHCC). I consent to the release of information regarding my healthcare to the MHCC *if indicated,* with the understanding that it will be held confidential per our privacy policy.**
   ☐ **Accept**
   ☐ **Decline**

7. I have had the opportunity to discuss the information provided above and any questions have been answered to my satisfaction. I hereby give my informed consent for Care and Treatment.

_____

Signature Date

1313 Park Boulevard, Rm. A-180 San Diego, CA 92101
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