

**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

**San Diego City College
Student Health Clinic**

**ADDENDUM TO GENERAL CONSENT FOR CARE AND TREATMENT
CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES**

Name: _____

Student ID# _____

1. The purpose of this form is to give my additional Informed Consent to Participate in Telemedicine Services

2. I have read and signed the Student Health Clinic (SHC) General Consent for Care and Treatment. I understand that all provisions of the General Consent for Care and Treatment also apply to my Consent to Participate in Telemedicine Services including my right to withdraw Consent to Participate in Telemedicine Services at any time, SHC eligibility and limitations of services, my right to discuss my treatment plan and be informed of the risks and benefits of my treatment plan, provisions for the confidentiality of medical information, and sharing of information with our professional team including the Mental Health Counseling Center. Note that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.

3. Telemedicine Services. Telemedicine involves the use of audio, visual or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunication technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

4. Risks/Benefits and Alternatives. The benefits of telemedicine include having access to medical services without having to be present physically in the clinic. This is especially beneficial during the COVID-19 pandemic emergency. A potential risk of telemedicine is that because of your specific medical condition or due to technical problems, a face-face consultation still may be necessary after the telemedicine appointment. You may be referred to a healthcare provider or facility in the community if necessary. Also, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to face visit with a healthcare provider where available.

5. 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 to Participate in Telemedicine Services.

Signature

Date