SHaW Consent for Treatment

I hereby authorize UConn Student Health and Wellness staff to provide medical and mental health treatment, which may include medications for treatment of illnesses/injuries, and to arrange for emergency medical care if circumstances render me incapable of making such decision.

I understand that to facilitate the best care for my wellbeing, it may be necessary to share my medical information between departments within Student Health and Wellness. This information will be shared with the intended purpose of coordinating my care in the event that I require an urgent or emergent on-call response.

I hereby authorize Student Health and Wellness to disclose my medical records and/or information from such records to appropriate University personnel and/or Emergency Contacts identified within my records in the event of a health or safety situation as determined by the Student Health and Wellness staff.

I understand that Student Health and Wellness staff may disclose my medical records and/or information from such records to appropriate University personnel for purposes of treatment, payment and healthcare operations, and hereby consent to such disclosures.

I understand that any vaccine administered at Student Health and Wellness may be shared with the Department of Public Health, including demographics such as race, ethnicity, and address.

I may opt to schedule a telehealth appointment. Telehealth allows my medical provider and/or mental health provider to diagnose, consult, treat and educate using video-conferencing or telephonic services. By agreeing to a scheduled telehealth I hereby consent to participating in treatment and/or psychotherapy via video-conferencing or telephonic services. I understand that the same confidentiality standards that apply to a medical or mental health in-person visit also apply to a Telehealth visit.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures. My provider may, at any time, determine that due to certain circumstances, Telehealth is no longer appropriate, and recommend that resumption of in-person sessions.

I also understand there are exceptions to confidentiality wherein Student Health and Wellness may be required to disclose information from my medical record, including mandatory reporting of child, elder, and dependent adult abuse and in the case of credible threats of violence toward a reasonably identifiable person.

By signing below, I authorize Student Health and Wellness to submit to my insurance and agree to take responsibility for all charges whether or not paid by insurance. I acknowledge that my PeopleSoft account may be put "on hold" for unpaid charges incurred at Student Health and Wellness. Signature(s) below indicates understanding of, and agreement with the above information.

Student Signature: Date:	Parent/Guardian Signature: Date: If you are under the age of 18 years old, your parent/guardian must sign
Print Student Name:	Print Parent/Guardian Name: