Moorpark College Student Health Center

CONSENT FOR TREATMENT

Student ☐ Staff ☐ Male ☐ Female ☐ Student ID # _____

Last Name: _____ First Name: _____ Middle: _____

Birthdate: _____ Phone/Cell: _____/_____

Address: _____ City: _____ State: _____ Zip: _____

Do you have insurance? Yes ☐ No ☐ Insurance Company Name: _____

Type of Insurance: HMO ☐ PPO ☐ Other: _____

Emergency Contact: _____ Phone: _____

Consent for Treatment and Limits of Confidentiality

I hereby grant Moorpark College Student Health Services 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 an overview of the Ventura County 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.

_____ _____

Signature Date

_____ _____

Parent/Guardian, if student is a minor Date

This Consent for Treatment is valid until June 30, 2009.

(TURN PAGE OVER)

Moorpark College Student Health Center

MEDICAL RECORD DISCLOSURE RECORD

Patient Name: _____ Date of Birth: _____

Authorized Methods of Communication (Check all that apply)						
☐	**Personal Telephone**	☐	**Work Telephone**	☐	**Written Correspondence**	**Other**
Number:		Number:		☐	Mail/Delivery service	
☐	Leave call back number only – do not leave message	☐	Leave call back number only – do not leave message	☐	Fax Number:	
☐	Okay to leave detailed message with person	☐	Okay to leave detailed message with operator	☐	E-mail at residence:	
☐	Okay to leave detailed message on answering machine	☐	Okay to leave detailed message on personal voice mail	☐	E-mail at work:	

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Record of Disclosures						
Disclosure Date	**Disclosed to: Name/Address Telephone**	**Description and Purpose of Disclosure** If copy of authorization is attached check box.		**Type of Discl***	**Initials**	**Method of Discl****
			☐			
			☐			
			☐			
			☐			
			☐			

* T = Treatment; P = Payment; O = Health Care Operations Activities
** M = Mail; P = Telephone; F = Fax; E = Email; OT = Other specified mode of delivery