Evergreen Valley College Student Health Services

HEALTH INFORMATION PRIVACY PRACTICES ACKNOWLEDGMENT OF NOTICE
and
CONSENT FOR TREATMENT

_____	_____	_____
Last Name	First Name	Employee / Student ID#

(HIPAA): I have received the Notice of Privacy Practices, and I have been provided an opportunity to discuss it with EVC Student Health Services personnel.

Initial: _____

CONSENT FOR TREATMENT: In the case of routine health examinations, immunizations, diagnostic procedures, treatment of illness and/or injuries, permission is hereby granted to treat the student named below at the Student Health Services, San Jose/Evergreen Community College District, and to make necessary referrals to private physicians and other community facilities as indicated.

OUT-OF-CLINIC SERVICES: I certify that I have been informed that payment for any medical services (including laboratory and X-ray examinations) performed by a non-health center physician or medical facility is my responsibility, even though it may be recommended by a health center physician or nurse.

_____

Signature of Student / Employee Date

_____

Signature of Witness Date