

**UNIVERSITY HEALTH
SERVICES**
UNIVERSITY OF WISCONSIN-MADISON
333 East Campus Mall
Madison, WI 53715-1381
<http://www.uhs.wisc.edu>

MR# _____
Name _____
BD _____ Gender _____
ID# _____ Date _____

University Health Services (UHS) Information and Consent Form-Students

Authorization to Release Information

I understand that as part of my care, UHS maintains health records. Use and disclosure of records maintained by UHS are protected under the Family Educational Rights and Privacy Act (FERPA) and by Wisconsin State Law. By signing this form, I authorize University Health Services' use and disclosure of my health information to carry out treatment, billing and healthcare operations and to myself.

I may revoke my consent in writing except to the extent that UHS has already made disclosures relying on my prior consent or where disclosure of my information is permitted or required by law. I have the right to refuse to sign this authorization. If I do not sign this consent, UHS may decline to provide treatment.

More information regarding how medical information is protected is provided in the UHS Privacy Information for Students. A copy of this document is available from any UHS staff member or at www.uhs.wisc.edu.

Limits of Confidentiality

UHS takes its commitment to confidentiality very seriously. Confidentiality means that, in general, information contained within my records cannot be disclosed without my consent. However, there are certain exceptions:

- As required by federal or state laws;
- When not doing so might result in physical harm to myself or someone else;
- In situations involving physical or sexual abuse of children or vulnerable adults; and
- State and Federal law requires all UHS employees, as employees of the University, to inform the Office of the Dean of Students about any report made by a student seen at UHS if the student discloses that he or she has been sexually assaulted. No information that allows the student to be identified will be reported.

Payment

Many services provided at UHS are pre-paid by the Student Health Fee. I understand that I will be informed if a health care provider recommends a service or medical item from UHS that is not covered by the Student Health Fee. Payment for this service is my responsibility as the patient. I will receive a Statement of Service from UHS which I may submit to my insurance company. With the exception of the Student Health Insurance Plan (SHIP), **UHS will not bill insurance, verify insurance coverage, or accept assignment of insurance benefits.** If I intend to seek payment or reimbursement from my insurance, I understand it is my responsibility to verify the terms of my coverage by contacting my insurance provider before services are received. UHS is out-of-network for all health insurance plans except the Student Health Insurance Plan (SHIP).

Payment for services is due within 30 days of service. I understand that if my UHS bill is not paid within 60 days, a hold will be placed on my student account. This hold will prevent future enrollment and access to my student records. After 90 days, in accordance with University policy, any unpaid bill will be forwarded to a collection agency.

Consent for Medical Treatment

I voluntarily consent to be treated. This may include routine diagnostic, radiology and laboratory procedures and medication administration by my healthcare provider, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination at UHS. An additional informed participation form is required for mental health treatment.

(continued)

Patient/Client Right and Responsibilities

As a patient or client at UHS, I understand that I have certain rights and responsibilities. A copy of the UHS patient/client rights is available from any UHS staff member or at www.uhs.wisc.edu.

Contact Information

It is UHS' normal practice to communicate with patients through their MyUHS account about health matters, such as the results of a lab test. Sometimes UHS may leave messages on my voicemail. I have the right to request that UHS communicate with me in a different way, and UHS will agree to reasonable requests. To protect confidentiality, UHS does not communicate with patients via e-mail except for appointment reminders. Electronic communications should be sent through MyUHS.

Certification

By signing this form or clicking the "I consent" box, I certify that:

- I have read this form or it has been read to me, and I am satisfied that I understand its contents.
- My questions have been answered to my satisfaction.
- I consent to communicate with my UHS provider through MyUHS.
- I authorize University Health Services' use and disclosure of my protected health information to carry out treatment, billing, and healthcare operations.
- I consent to treatment at UHS.

PRINT YOUR NAME

DATE

SIGNATURE

Student ID #

YOU WILL BE PROVIDED WITH A SIGNED COPY OF THIS FORM UPON REQUEST