General Consent Form:

Patient: _____ DOB: _____Date: _____

Consent for Medical Treatment:

I hereby voluntarily consent Touro University Student Health and/or their consultants to administer medical and surgical services, required immunizations, TB testing, and to perform emergency procedures, as necessary, to refer to licensed personnel when indicated (including outside Hospitals). I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

Initial: _____

Release from Responsibility for Loss of Valuables:

Touro University Student Health is not responsible for valuables, including money, jewelry, glasses, documents, and other personal items.

Initial: _____

Release from Responsibility:

If I should leave the Clinic against medical advice or prior treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

Initial: _____

Authorization for Release and use of Medical Information for Treatment, Payment, or Healthcare operations:

I authorize the Clinic or the Clinic's designee to disclose to payers including, but not limited to, insurers, Workers Compensation carriers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic charges ("Third Party Payers"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payers to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic operations.

Initial: _____

Notice of Privacy Practice:

I acknowledge that I have been given a copy of Toure University Student Health's Notice of Privacy Practices. My initials acknowledge receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

Initial: _____

I have read the above consent and various releases and herewith execute the same voluntarily. A copy of this document shall be valid as the original and a copy shall be provided to me. This consent will remain effective for your entire enrollment as a student of Touro University California.

Signature: _____ **Date:** _____

STUDENT HEALTH
1310 CLUB DRIVE BLDG H-89 STE. 1537
VALLEJO, CALIFORNIA 94592
T: (707) 638-5220 F:

Revised 06/23/2025 asmith

General Consent Form:

tuc.studenthealth@touro.edu

Touro University California Student Health Center Notice of Privacy Practice:

Your rights regarding your medical and personal information, how it may be used, disclosed, and how to obtain access to this information:

Your Rights: You may obtain a copy of your electronic or paper medical records, request correction of any misinformation therein, request confidential communication, ask for limitations on information that may be shared, obtain a list of those with whom your information may be shared, choose someone to act for you, or file a complaint if you believe there has been a violation of your privacy rights.

Your Choices: You have some choice in how your information may be shared such as: Family and friends regarding specific medical conditions; how you may receive disaster relief; and provisions for mental health care. Student Health will not use or sell your information for marketing purposes or for any other reason(s).

Student Health Use and Disclosure: Student Health may share and use your information as you are treated for purposes such as billing for our services and operations; protecting public health; other safety issues; and compliance with the law. Other considerations are possible response to legal actions and lawsuits, worker compensation issues, and information for law enforcement and/or other government requests.

Your Rights Pertaining to your Health Information and Student Health Center Responsibilities: You may ask to view and / or obtain either a paper or electronic copy of your medical record and/ or other health information on file. Student Health will provide a copy or summary upon your written request, usually within 30 days. You may be charged a reasonable fee for the provision of same.

You may ask to have a correction pertaining to your health information you believe to be incorrect or incomplete. The appropriate Student Health Center member may say no to your request. For such an action, you will be informed of the said response within 60 days. If Student Health declines to correct any alleged inaccuracy in your file you may appeal the decision and submit your proposed correction. However, that submission does not assure that your correction will be accepted as a permanent part of your file.

General Consent Form:

Reasonable confidential communication: This shall be available to students who request contacts via a different mailing address or a home phone vs. an office phone.

Limitations on shared information: Shared information regarding and associated with items such as treatment, payments or Student Health Center operations will be considered. Student Health Center is not required to agree to your request, and the right to say "no" is reserved if it would affect your care. If you are paying for service or health care "out-of-pocket" in full, you may ask that the information for the purpose of payment or our operations not be shared with your health care insurer. Student Health Center will say "yes" unless we are required by law to share that information.

Student Health Center Responsibility: Maintain privacy and security of your protected health information and advise you of any breach that may occur involving your protected health information. Any concerns that you may have about any of the above information should be called to the attention of the Director of Student Health.

A copy of this form will be given to you during your first medical visit to Student Health or upon your request.

For more information: www.hhs.gov/for/privacy/hippa/understanding/consumers/notidepp.html.

_____ _____

Signature of Student Date

_____

Printed name of Student

Revised 06/23/2025 asmith