TOURO UNIVERSITY
CALIFORNIA

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.

(____)

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.

(____)

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.

(____)

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE 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.

(____)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of Touro 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.

(____)

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: _____

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Vallejo, California 94592
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