UF | Student Health Care Center
UNIVERSITY of FLORIDA

CONSENT AND AUTHORIZATION

UFID:_____ PATIENT NAME:_____ VISIT DATE:_____

1. **Authorization for Medical Care:** I hereby authorize the healthcare providers of the University of Florida (UF) Student Health Care Center (SHCC), their agents or consultants ("health care providers"), to perform diagnostic and treatment procedures that, in their judgment, may become necessary while I am a student at UF.

2. **Release of Medical Information:** I understand that the SHCC works in conjunction with SHCC Psychiatry and UF Counseling and Wellness Center (CWC). I authorize the release information between these entities based on need for diagnosis and treatment.

   I authorize release of any information to county, state or federal public health agencies, as required by law. Parental consent for diagnosis and treatment is required for patients under the age of 18.

   I understand that I am responsible for further charges incurred and authorize the University Faculty Group Practice and SHCC to release information from my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests) and any other information that may be required to secure payment for charges incurred by me or on my behalf to: (1) any University facility or affiliated provider; (2) the guarantor on my accounts, which includes my parents; and (3) my or my parents' insurance.

3. **Responsibility for Payment:** I agree to be personally responsible for payment of any care that is not covered by the University Health Fee*, or my or my parents' insurance, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments. I understand that if the charges are billed to my parents' insurance, my parents could receive a statement from the insurance company regarding the services I received.

   *The University Health Fee, paid as part of tuition, covers patient financial responsibility associated with most SHCC office visits (for example, when a medical provider evaluates a sick patient but does not order any tests, procedures or prescriptions), and with telephone or online services initiated by the patient. Patients are financially responsible for items not covered by the health fee; these include, but are not limited to: health insurance premiums; hospital visits; external community providers/facilities; physicals; procedures; X-rays; lab tests; medical equipment; prescriptions; non-prescription medications; vaccinations; massage; and physical therapy.

   While SHCC does perform some labs in house, others may be sent to reference labs according to the type of lab and my insurance. I may receive bills from the following reference labs, Quest, LabCorp, or UF Pathology.

   I understand if I do not cancel my appointment and do not show, I will be assessed a $25 no show fee.

NOTE: If you would like to communicate with a third party about your current condition(s), please give your healthcare provider contact information and verbal permission. In the event of an emergency, Emergency Contact information will be obtained from the Office of the University Registrar.

NOTICE OF LIMITED LIABILITY
The diagnostic and treatment procedures provided by my health care providers is subject to the provisions of Section 768.28, Florida Statutes, which limits recovery for a claim or a judgment by any one person to $200,000, or any claim or judgment, or portion thereof, which, when totaled with all other claims or judgments arising out of the same incident or occurrence, to $300,000.

Patient/Guardian/Guarantor_____ Date: _____

Printed Name/Relationship to patient: _____ Self Guardian Guarantor Insured