THE UNIVERSITY OF ARIZONA CAMPUS HEALTH SERVICE MEDICAL AND COUNSELING & PSYCH SERVICES CONSENT FOR TREATMENT AND INFORMATION SUMMARY

IF YOU ARE UNDER THE AGE OF 18, HAVE A PARENT CALL 520-621-9202 TO OBTAIN THE CONSENT FORM OR LOOK ONLINE AT HEALTH.ARIZONA.EDU/MEDICAL-RECORDS

Welcome to the University of Arizona (UArizona) Campus Health Service (CHS), Counseling & Psych Services (CAPS), and other services provided by CHS.

This Consent for Treatment form: 1) offers you information regarding our services; and 2) gives us your written consent to provide such services. Please read it carefully and let your provider know if you have any questions before signing this form.

PURPOSE: Our mission is to offer high-quality mental and medical health services to currently enrolled UArizona students, as well as to faculty and staff.

GENERAL CONSENT TO TREAT: By agreeing below, I, (or my legally authorized representative on my behalf) authorize UArizona Campus Health Service and its workforce members to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

CONFIDENTIALITY AND RECORDS: For a full description please see our privacy practices below. CHS/CAPS records regarding your medical and mental health treatment and services are stored on a secure server, entirely separate from your academic records. Your CHS/CAPS records are available to designated CHS/CAPS workforce members, including CAPS mental health providers, CHS medical providers, dietitians, and nursing supervisors. You have the right to access information in your Campus Health/CAPS health record. Your records are available to you via the PatientLink portal, and visit records appear after completion by your provider. Your mental health providers may choose to withhold some records if they believe that the release of these records would result in you or others experiencing harm. Your provider will notify you should records be withheld. Requests for CAPS records that predate April 5th, 2021, must be in writing to our Medical Records office.

MENTAL HEALTH CARE INFORMATION:

Description and outcome: We are primarily a brief treatment unit and will assist in securing community resources when we believe you could benefit from more extensive or a different type of treatment than we offer. Treatment may include discussion of emotional issues, lifestyle issues, behavioral patterns, and family and/or relationship dynamics. Methods may include the use of educational materials, expressive methods, and stress management techniques, and may involve referral to other types of treatment, as indicated. Benefits of treatment may include reduction of symptoms, improved quality of life, emotional well-being, and improved academic performance. This

process requires effort on your part, may require you to face difficult issues to effect changes, and may involve emotional risk or discomfort. There is no guaranteed outcome. Psychiatric medication may be recommended and, if you agree, prescribed. You have the right to discuss any medication concerns or questions with your provider and may withdraw voluntary consent for medication at any time.

In most cases, on your first visit, a CAPS provider will meet with you individually to assess your needs, provide therapeutic support, and work collaboratively with you to develop a Care Plan. You will be informed about mental health services provided at CAPS including Self-Help resources, Workshops, Groups, Psychiatry, Specialty Services, and Peer Support services. In some cases, you may be referred to other appropriate UArizona resources, or assisted in securing community resources. Appointments with our psychiatry staff are by CAPS/CHS referral only. In the event of an emergency or unavailability of your assigned provider, you may be offered an appointment with another member of our treatment team.

Treatment planning: You have the right to participate in treatment decisions and planning. You can terminate this treatment relationship at any time and can accept or decline any recommended treatment. You may withdraw this consent to treatment at any time and will then be advised of the ramifications of such withdrawal from services. A CAPS provider may terminate the professional relationship when deemed therapeutically necessary. If that occurs, you will be given other treatment options, as appropriate.

Notice of Privacy Practices for Protected Health Information: Campus Health is committed to protecting the privacy of health information we create or receive about you. We understand that your health information is personal, and that protecting that information is important. We are required by law to:

- Make sure that your health information is kept private (with certain exceptions)

- Give you this Notice of our legal duties and our privacy practices with respect to health information about you, and

- Follow the terms of the Notice currently in effect:

https://health.arizona.edu/notice-privacy-practices-protected-health-information

I acknowledge that I have received a copy of, and consent to the use or disclosure of my health information as set forth in the University of Arizona Campus Health Service Notice of Privacy Practices.

_____ Initial to accept

Writing my name below indicates my consent for treatment and acknowledgement of the information in this summary. I understand that if I am a minor, then CHS must obtain written permission from my legally authorized parent/guardian before I receive treatment.

_____ _____

Signature of Patient or Person Authorized to Consent Date

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Print Name