

I hereby give consent to the clinical staff of the Student Health Center of California State University, Los Angeles, for medical examination, diagnostic procedures (including x-ray, laboratory tests), administration of medical or surgical treatment, or for any other care when any, or all of the foregoing is deemed necessary by and is to be rendered under the general supervision of a qualified California licensed health care provider. I understand that my treatment will be confidential and my medical records will not be released to anyone without my permission except by subpoena, insurance reporting, or other legally required reporting. Review of medical records by the Quality Assurance Committee is conducted to ensure the appropriateness, necessity and the quality of services.

I also understand that the Student Health Center is limited in its ability to provide continuous and/or comprehensive health care for me as the Student Health Center is closed in the evenings, on weekends, during holidays, and the provision of care is based on enrollment status.

Patient's Signature

Patient's CIN:

Date

Print Last Name

First

Middle

Forms/Med-rec/Authorization Consent & Treatment Jan 04



California State University, Los Angeles
STUDENT HEALTH CENTER

**AUTHORIZATION AND CONSENT
FOR TREATMENT**

Last Name _____
First _____
CIN _____