



## Consent for Treatment and Notice of Collaborative Care

Student/Patient Name: \_\_\_\_\_

Student ID#: \_\_\_\_\_

Emory University provides students with access to several clinical offices within Emory University. On the Atlanta Campus, this includes Counseling and Psychological Services (CAPS), Emory University Student Health Services including psychiatry (SHS), and the Office of Respect (OOR). On the Oxford Campus, this includes the Center for Counseling and Wellness (CCW) and Student Health Services (OXSHS).

**Consent for Treatment.** I consent to routine diagnostic and treatment procedures/examinations including, but not limited to injections, infusions of intravenous fluids, laboratory testing, administration of medications, administration of non-live (inactivated) vaccines, radiographic procedures, physical tests, therapies, medical, mental health and/or behavioral assessments and treatments, monitoring, psychological counseling, routine care considered reasonably necessary for the care and treatment of my condition during the encounter (“Procedures”) with CAPS, SHS, OOR, CCW, and OXSHS. I understand that Procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and prognosis before allowing the Procedures to be performed and a separate consent may be required. I consent to treatment and care provided by a team of healthcare providers, which may include mid-level providers such as physician assistants or advanced practice nurse practitioners. I understand that my clinical team may also include licensed clinical social workers, counselors, and psychologists. My healthcare team could include students, including medical students, interns, residents, fellows, physician assistants, nurses and other allied health students in training. I understand that Emory University’s mission includes training physicians and other medical and allied health personnel, and graduate students. I consent to these individuals observing or participating in my Procedures for the purposes of training, research, or education unless I specifically decline. I acknowledged that the practice of medicine is an inexact science and that no guarantees of assurances have been made to me regarding my Procedures or the results of such Procedures. If I am asked to participate in a research study, I may refuse to participate, and my refusal will not affect or compromise my access to medical services.



Chaperone at SHS:

I understand that I have the right to request a chaperone present at any time when I am with an SHS provider. A chaperone is required for any sensitive physical examination unless I decline a chaperone.

Students/Patients Who are Minors:

Under Georgia Law, I understand that a minor younger than 18 years of age must generally receive written consent from a parent, guardian, or person in loco parentis to receive treatment. A minor, however, may consent to treatment related to substance abuse, sexually transmitted illness, female contraception, or pregnancy without parental consent. A minor with a referral from a medical provider for treatment related to substance abuse may access counseling services with CAPS, CCW, or OOR without parental consent.

Recordings:

I understand that health care professionals within CAPS, CCW, and OOR may record clinical sessions for the purposes of supervision, training and/or quality assurance, and I consent to being recorded for these purposes. I further understand that these recordings are not part of my clinical record, and all recordings are securely stored and purged (erased) on a regular basis. I understand that I will be notified in advance of any recording and acknowledge that I have the opportunity to discuss any questions or concerns related to the recording of clinical sessions with CAPS, CCW, and OOR staff members.

Telephone Consumer Protection Act Consent:

I expressly consent to receive phone calls and text messages from CAPS, SHS, OOR, CCW, and OXSHS and service providers, vendors, and other Emory and non-Emory parties acting on their behalf at any telephone number(s) that I provide or that they may obtain from me. Such calls and texts may be made using an automatic telephone dialing system and/or prerecorded or artificial voice and may be made for any non-marketing purpose, including, but not limited to communications about my treatment, medication assistance, insurance, benefits, or account; appointment reminders; balance due and payment reminders; and debt collection attempts. I understand that I may revoke my consent at any time by notifying CAPS, SHS, OOR, CCW, and/or OXSHS through reasonable written means.

Termination of Medical or Mental Health Treatment

I understand that I have the right to terminate treatment at my discretion. I also understand that my treatment provider reserves the right to terminate treatment for reasons including, but not limited to, conflict of interest, my failure to participate in therapy/care, or needs that exceed the services provided by any of the clinical offices listed above. I understand that if my needs exceed the scope of services provided, a referral can be arranged by my service provider. I also understand that upon either my or my provider's decision to terminate treatment, it is



recommended that I participate in at least one termination session in order to facilitate reflection and a smooth transition to another treatment provider.

**Notice of Collaborative Care.** For purposes of the following Section, CAPS, SHS, OOR, CCW and OXSHS are referred to as the “Emory Health and Wellbeing Clinical Offices.”

Information Sharing Among Emory University Clinical Offices and Waiver of Privileges:

I understand that the Emory Health and Wellbeing Clinical Offices may share such information from my treatment records with one another as is necessary to provide collaborative clinical care delivery and coordination, including for clinical consultation, referrals, and supervisory purposes. If my treatment records contain information related to certain infectious diseases (including without limitation, HIV/AIDS confidential information), substance abuse and/or mental health, I waive any privileges for purposes of such disclosures of such information among the Emory Health and Wellbeing Clinical Offices for the purposes described in this paragraph.

I understand that Emory Health and Wellbeing Clinical Offices records related to clinical services are maintained separately from non-clinical university records and official transcripts and are used and disclosed only as permitted or required under applicable law. Examples of circumstances under which information from treatment records may be disclosed without an individual’s consent include a) suspected abuse or neglect of minors, the elderly, or disabled adults; b) imminent risk of life-threatening harm to self and/or others; and c) court orders.

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*Signature of Student/Patient*

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*Date*

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*Signature of Parent or Guardian*

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*Date*

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*Relationship to Student/Patient*