

# SUNY Cortland Student Health Service

## Consent for Treatment of Minors

(Statement by Parent / Guardian for students under age 18.)

**I hereby authorize medical treatment for my minor student that may be recommended by the Student Health Service:**

I have reviewed the required medical forms submitted on my minor student's behalf and attest that they have been completed accurately and to the best of my knowledge.

I consent to the use or disclosure of my minor child's protected health information by the Student Health Service staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my minor student's protected health information is used or disclosed for the above purposes. The Student Health Service is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide emergency treatment.

The "Notice of Privacy Practices" describes my rights as well as the Student Health Services rights and responsibilities with respect to protected health information.

\_\_\_\_\_  
Minor Student Name (print) C#

\_\_\_\_\_  
Date of Birth (MM/DD/YY)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Parent/Guardian Name (print)

\_\_\_\_\_  
Date