Consent Form

By signing this Consent Form, I agree to the following:

1. I consent to receive treatment from CMHC clinician(s).

2. I have read and understand that Texas State Law permits or requires the disclosure of confidential information without my consent under very specific circumstances (see Notice of Privacy Practices).

3. I am giving my consent to the Counseling and Mental Health Center ("CMHC") to use my health information from my record for purposes of providing me treatment and for coordination of my care as defined and explained in more detail in the Center's Notice of Privacy Practices ("Notice"). CMHC's Notice provides more complete information about how protected health information may be used, and a copy of this Notice is available at http://cmhc.utexas.edu/confidentiality.html or at the CMHC front desk upon request. I understand that CMHC reserves the right to modify its Notice, and a revised Notice will be provided upon request.

4. I authorize the sharing of information among CMHC clinicians who are involved in my mental health treatment.

5. I authorize the sharing of the following information about my CMHC visits with University Health Services ("UHS") health care providers: dates of visits, name of CMHC clinician(s) seen, medications, allergies, diagnoses, drug and alcohol abuse, suicidal and homicidal thinking, and other information deemed appropriate for safety and continuity of care.

6. In the event that I see a CMHC psychiatrist, I authorize the sharing of documentation relevant to my psychiatric treatment with UHS healthcare providers. In the event that I accept a referral to a UHS health care provider for my care, I authorize the sharing of my counseling record with UHS health care providers.

7. I have the right to ask CMHC to restrict how my protected health information is used to carry out treatment or health care operations. I understand that CMHC is not required to agree to my request for restrictions, but if it does, I understand that CMHC is bound by its agreement.

8. I may revoke this Consent Form at any time by notifying CMHC in writing of my intention to revoke it. My revocation letter will not affect any use of my health information by CMHC for

treatment or health care operations before the revocation is received. The revocation letter shall be addressed to:

Counseling and Mental Health Center
ATTN: Records Office
University of Texas
1 University Station, A3500
Austin, Texas 78712

9. **I will be charged $25 if I miss a scheduled CMHC appointment (except group counseling appointments) without canceling by 12:00 noon on the day *prior* to the appointment.** I understand that these charges will appear on my UT "What I Owe" page, and that anyone given access to that page will be able to view the charge.

I hereby grant my permission for any counseling, testing, or diagnostic evaluation that may be deemed necessary by my clinicians. I understand that treatment is a joint effort between my clinicians and myself, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all fees. I know that I can end treatment at any time and that I can refuse any requests or recommendations made by my clinicians.

Student Signature: _____

Student Printed Name: _____

Witness: _____ Date: / /