



# University Women's HealthCare

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### CONSENT FOR MEDICAL CARE

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I wish to have treatment given to:  me  my child  my ward by University Women's HealthCare. I voluntarily consent to routine diagnostic and therapeutic procedures, such as physical exams, vaccinations, and lab tests. As part of the care to be given, a test may be performed for human immunodeficiency virus infection (HIV /AIDS,) hepatitis, or other blood-borne infectious or communicable diseases, if the doctor orders the test for diagnostic purposes because of my / the patient's medical history, symptoms or conditions.

I hereby acknowledge that I have read and fully understand the information set forth above and that any questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

I hereby state that I am the  parent  legal representative of the patient and am authorized to sign on their behalf.

\_\_\_\_\_  
Parent / Legal Representative

\_\_\_\_\_  
Date

I have reviewed the above information with the patient, parent or legal representative as appropriate.

\_\_\_\_\_  
Staff Representative

\_\_\_\_\_  
Date

## University Women's HealthCare

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided University Women's HealthCare Notice of Privacy Practices:

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

I acknowledge that I declined University Women's HealthCare Notice of Privacy Practices provided:

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date