UNIVERSITY HEALTH SERVICES
UNIVERSITY OF WISCONSIN-MADISON
333 East Campus Mall
Madison, WI 53715-1381
http://www.uhs.wisc.edu

MR#_____
Name_____
BD_____ Gender_____
ID#_____ Date_____

University Health Services (UHS) Information and Consent Form-Non Students

Acknowledgment Receipt

By signing this form, I acknowledge that University Health Services has given me a copy of its Notice of Privacy Practices.

Limits of Confidentiality

UHS takes its commitment to confidentiality very seriously. Confidentiality means that, in general, information contained within my records cannot be disclosed without my consent. However, there are certain exceptions. These are explained in the Notice of Privacy Practices.

Consent for Medical Treatment

I voluntarily consent to be treated. This may include routine diagnostic, radiology and laboratory procedures and medication administration by my healthcare provider, his/her assistants or his/her consignees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination at UHS.

Patient Rights and Responsibilities

As a patient at UHS, I understand that I have certain rights and responsibilities. A copy of the UHS patient rights is available from any UHS staff member or at www.uhs.wisc.edu.

Contact Information

It is UHS' normal practice to communicate with patients through their MyUHS account about health matters, such as the results of a lab test. Sometimes UHS may leave messages on my voicemail. I have the right to request that UHS communicate with me in a different way, and UHS will agree to reasonable requests. To protect confidentiality, UHS does not communicate with patients via e-mail except for appointment reminders. Electronic communications should be sent through MyUHS.

Certification

By signing this form or clicking the "I consent" box, I certify that:

- I have read this form or it has been read to me, and I am satisfied that I understand its contents.
- My questions have been answered to my satisfaction.
- I acknowledge that I have received the UHS Notice of Privacy Practices.
- I consent to communicate with my UHS provider through MyUHS.
- I consent to treatment at UHS.

_____ _____
PRINT YOUR NAME DATE SIGNED

_____ _____
SIGNATURE DATE OF BIRTH

YOU WILL BE PROVIDED WITH A SIGNED COPY OF THIS FORM UPON REQUEST