Icahn School of Medicine at Mount Sinai

Student Health Center

Mount Sinai
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CONSENT FOR PROVIDER - PATIENT COMMUNICATION

I, _____, hereby consent to have Student Health staff communicate with me or members of their staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mails communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of her office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

GENERAL CONSENT TO TREATMENT

By signing below, I, _____, authorize the staff of the Student Health Center to conduct diagnostic examinations, tests, administer vaccines and to provide any medications, treatment or therapy necessary to maintain my health. I understand that the health care provider will explain to me the reasons for any particular test or procedure, the available treatment options as well as alternative treatment.

I have been given information regarding HIV testing, and the HIV virus, that testing is voluntary and can be done anonymously, how my HIV related information will be kept confidential and what laws protect people with HIV-AIDS from discrimination. I understand that the results will be documented in my medical records.

Consent for HIV related testing remains in effect until I revoke it. I may revoke my consent orally or in writing at any time. As long as this consent is in force, the staff at the Student Health Center may conduct additional tests without asking me to sign another consent form. The provider will notify me if other HIV tests will be performed.

☐ **I do not want an HIV test**

Signature: _____ Date: _____