Farmingdale State College
State University of New York

Consent to Receive Services and Privacy Policy

I hereby agree to assessment/consultation/treatment at the Farmingdale State College Health and Wellness Center, and I understand the following:

- Services are available only to currently enrolled students. Most services are fully or partially covered by my student health fee.
- I have the right to be seen in a timely manner, to receive quality care, to be treated with respect, and to receive feedback from my health care provider.
- I have the right to refuse diagnostic and/or treatment services.
- The Health and Wellness Center staff operate as a team. They may confer with one another as is professionally necessary to provide the best possible service to me.
- The Health and Wellness Center staff will treat any information I share during my contacts with them with the strictest confidentiality. I also understand that there are important legally mandated exceptions to confidentiality. These include:
    1. Notification of relevant others when a health care provider determines that a student is an immediate danger to his/her self or others
    2. Incidences of suspected elder or child abuse, neglect, or maltreatment
    3. Legal action, in which a judge may subpoena the College to provide copies of clinical records.

  Otherwise, I understand that confidential information will not be disclosed outside the Health and Wellness Center without my written authorization to do so.
  PLEASE NOTE: The exceptions to confidentiality are extremely rare.
- Signing this form does not waive my confidentiality and privacy rights.
- I am responsible for the following:
    1. Respectful interactions with Health and Wellness Center staff
    2. **Attendance at scheduled appointments unless rescheduled or canceled at least 24 hours in advance**
    3. Active participation and cooperation in the treatment process
    4. Notification to my health care provider if my problem or condition worsens.

I have read the above statements regarding the Health and Wellness Center and fully understand them. I have addressed any questions with a staff member. I also understand that this consent will remain in effect until I am no longer a Farmingdale State College student.

Student Signature _____ **Date** _____/_____/_____

Staff Signature _____ **Date** _____/_____/_____

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HIV Test Consent/Declination Form

I have reviewed the seven points of information regarding HIV testing, how HIV can be transmitted, that there is treatment for HIV/AIDS, how to keep myself and others safe from HIV infection, that testing is voluntary and can be done elsewhere anonymously, how my HIV-related information will be kept confidential, and what laws protect people with HIV/AIDS from discrimination. *I understand that this testing is not anonymous, but rather confidential, and that the results will be documented in my medical chart.*

Consent for HIV-related testing remains in effect until I revoke it or until the following date _____. I may revoke my consent orally or in writing at any time. As long as this consent is in force, Farmingdale State College Health and Wellness Center may conduct additional related tests on me without asking me to sign another consent form. In that case, my provider will advise me if other HIV tests are recommended and will be performed, and will document them in my medical record.

I understand that the laboratory charge for HIV testing is $40, and that my insurance will be billed unless I specify otherwise. If uninsured, the laboratory will bill me directly at the address I specify. I understand that my insurance will be billed for any additional related testing as well, or if uninsured, the laboratory will bill me directly. I understand that medical information related to the HIV test will be released to my insurance company for billing purposes only and I give my consent to release such information to them.

I understand that should I test positive, the laboratory is mandated by NYS law to report those results to the NYS Department of Health. I understand that the Health and Wellness Center staff will work with me to arrange an appointment for care at a designated AIDS center, and will work with me regarding notification of my partner(s).

I have been given the opportunity to ask questions, which have been answered. Based on all of the information provided, I have decided that:

_____ I do want an HIV test.

_____ I do not want an HIV test.

_____ I wish to have anonymous HIV testing at an alternate site. Hotline numbers were provided to me.

Name :_____
Last First Middle

Date of Birth _____ **Student RAM ID#**_____

_____
Signature **Date**

Phone Number (_____) _____ ☐ **Home** ☐ **Cell**