WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
(973)-720-2360 · (973)-720-2257 · FAX: (973)-720-2632
300 POMPTON ROAD · WAYNE, NEW JERSEY 07470-2103 · WWW.WPUNJ.EDU

MEDICAL
CONSENT FOR TREATMENT & RELEASE

My signature below indicates acknowledgement that I have had a chance to read the **NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES AT THE COUNSELING, HEALTH & WELLNESS CENTER** for participation in **Health & Wellness services**. I understand I may request a printed copy of this policy at any time.

I have had an opportunity to ask any questions I might have regarding the contents of that Notice. I understand its meaning and hereby give my consent to participate in health services based on the rights and responsibilities enumerated therein.

Participation in health services may include routine health examination, preventative measures, medical treatment, first aid and necessary referrals to outside healthcare providers.

I understand that CHWC does not contract with all health insurers and it is my responsibility to know if my health insurance provides coverage for CHWC lab services or requires a referral or pre-approval for such services.

I understand that I may be financially responsible for any co-pays, deductibles and/or co-insurance not covered by my health insurance for any lab services completed at CHWC.

I also consent to the release of pertinent medical records to appropriate health care providers and parents/guardians in the event of an emergency.

Student's Name _____ **Student ID# 855**_____
(Please Print)

Student's Signature _____ **Date** ____/_____/_____

Parent/Guardian's Signature _____ ***Date*** ____/_____/_____
(Required only if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature _____ **Date:** _____

We attempted to obtain written consent for treatment and release but consent could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the consent.
_____ An emergency situation prevented us from obtaining consent
_____ Other (Please Specify) _____

Name/Signature of Office Staff: _____