

Loyola Marymount University Student Health Services

Consent for Treatment of a Minor

(Child or minor under the age of 18 years)

I hereby authorize medical treatment for my minor child/ward that may be recommended by the Student

Health Services:

- I consent to the use or disclosure of my minor child/ward protected health information by the Loyola Marymount Student Health Services (LMU SHS) staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.
- I understand that I have the right to request a restriction or limitation on how and to whom my minor child/ ward protected health information is used or disclosed for the above purposes. LMU SHS is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide emergency treatment.
- The "Notice of Privacy Practices" describes my rights as well as the LMU SHS rights and responsibilities with respect to protected health information.

Student Name (please print): _____

University ID #: _____

Parent/Guardian Name (please print): _____

Signature of Parent/Guardian: _____ Date: _____