

Health Services

Demographic and Consent Form

Legal Name _____ Preferred Name _____ Pronouns _____

Date of Birth ___ / ___ / ___ Student ID# _____ Email _____ Phone _____

Street Address _____ Residential Hall & Room _____

City _____ State _____ Zip Code _____

How may we reach you or leave a message? (check all that apply) Phone Email Mediat (EMR) USPS

Emergency Contact _____ Relationship _____

Phone Number #1 _____ #2 _____

Address _____

Emergency contact is for Health Services use ONLY.

Please contact the Office of Residence Life to update your emergency contact information for other notification purposes.

Consent for Treatment

I understand the information gathered by SMCM Health Services is confidential. My healthcare team may share information with the SMCM Counseling Services staff for non-urgent referrals with my written or verbal consent. Otherwise, I understand my healthcare information will not be shared outside of SMCM Health Services without my direct consent unless I am experiencing a medical or mental health emergency. If I require emergency treatment at SMCM Health Services or neighboring hospitals and am unable to provide consent for treatment due to incapacitation, I hereby permit emergency medical treatment, including surgery, if deemed necessary and/or lifesaving as deemed by the provider rendering care.

IF A MINOR IS INVOLVED, ordinarily the provider will attempt to contact the parent or guardian before rendering emergency medical treatment, including surgery, if deemed necessary and/or lifesaving.

I agree and consent to treatment.

I have read and understand the [Privacy Notice](#) (posted in the lobby and a paper copy is available upon request).

Patient Signature _____ Date _____

Parent/Guardian Signature (if under 18) _____

Print Name _____ Date _____

If the patient is under the age of 18, a parent/guardian signature is required for treatment unless stipulated here:

[Md. Code Ann., Health-Gen. II § 20-102](#)

[Maryland Minor Consent Laws](#)