EMORY UNIVERSITY | Student Health Services
Campus Life

Place label here

Consent for Mental Health Treatment

Student Name:_____ Student ID#:_____ DOB:_____

I consent to mental health evaluation and/or treatment (or for my minor child or ward under 18 years of age to participate in mental health evaluation and/or treatment) at Emory University Student Health Services by mental health staff, which may include attending psychiatrists, psychiatric residents supervised by attending psychiatrists, licensed clinical social workers, or other professionally licensed staff. I also authorize such treatment or diagnostic studies as, in the judgement of mental health staff, may reasonably be necessary to preserve and protect my health and wellbeing (or the health and wellbeing of my minor child or ward).

No guarantee is being made to me regarding results of treatment. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. I consent to be treated (or for treatment of my minor child or ward) with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable.

Communications between a psychiatrist or other professionally licensed mental health staff and a patient are confidential. Confidentiality prohibits the disclosure of information related to the mental health staff-patient relationship without consent from the patient.

I have completed the EUSHS-Authorization for Use/Disclosure of Protected Health Information, and have received and reviewed the Emory University Notice of Privacy Practices.

I can withdraw this consent for mental health treatment at any time by providing written notice to EUSHS staff.

_____ _____
Signature of Student/Patient Date

If the student/patient is under 18 years of age, this form must be signed by the parent or guardian:

_____ _____
Signature of Parent or Guardian Date 12/18

1525 Clifton Road, Atlanta, Georgia 30322
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