



KLOTZ STUDENT HEALTH CENTER
18111 NORDHOFF STREET, NORTHRIDGE CA 91330-8270
PHONE (818) 677-3666 -- TTY (818) 677-3692 -- FAX (818) 677-2304

GENERAL CONSENT FOR TREATMENT

The undersigned patient and/or responsible relative or person hereby consent to and authorize Klotz Student Health Center's physicians and medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, vaccinations and immunizations against diseases which may be now or during the course of the patient's care as an outpatient be deemed advisable or necessary.

Witness

Signature of Patient

Date

Witness

Signature of Responsible
Relation or Person

Date

The undersigned consents to the SHC contacting him/her by e-mail if needed regarding appointments and follow-up needs, and understands that e-mail may not be 100% confidential or secure and that messages may be read by others, intentionally or accidentally. I understand and consent to e-mail communications:

Signature of Patient

Date

E-mail Address

Fax #

Witness

Date

Patient Data - Please print
Name:
ID#:
Date of Birth: