



StudentName \_\_\_\_\_ DOB \_\_\_\_\_  
                    LastName                      First Name

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Bryn Mawr College  
Health and Wellness Center Medical Services  
Consent for Treatment

I hereby consent for Bryn Mawr College Health and Wellness Center Medical Services ("BMC Medical Services"), and its affiliated medical providers, nurses, and/or allied health professional students employed or participating in a clinical rotation to provide medical services to me. I am authorizing BMC Medical Services to treat me during my relationship with the College as an enrolled student unless and until I withdraw my consent in writing. I acknowledge that I am responsible for all charges incurred in connection with the medical care and services provided and I also understand that I am financially responsible for all charges incurred for any and all services that I receive from other providers outside of BMC Medical Services, even if BMC Medical Services recommends those other services or recommends those other services or refers me to such other providers. I approve the release of medical diagnostic information to my insurance company for payment purposes. I hereby certify that I have read fully the above authorization and by my signature below I consent to the above and further understand that no assurance or guarantee has been or will be made regarding the results of any medical services provided by BMC Medical Services, including but not limited to the provision of medical treatment or evaluation. In addition, I acknowledge that I have reviewed Bryn Mawr College's Medical Service Notice of Privacy Practices document.

\_\_\_\_\_  
Student's Signature (18 years of age or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parents' Signatures (if student is 18 years of age or younger)

\_\_\_\_\_  
Date