



Helpful Tips for Completing Release Forms Packet

UT Austin Release and Indemnification Agreement – Minor Form

- Complete the top of the form with the student's name and address
- Parent/guardian must sign & date the bottom as well as provide the parent address.
- The witness signature must be signed and dated from someone 18 years of age or older. It cannot be from the same person that signed under "signature of parent". A neighbor, friend, relative, sibling, or other parent may sign as the witness. It **does NOT** have to be signed by a notary.

UT Austin Media Release Consent and Waiver Form

- All blanks on this form must be filled.
- Complete the date
- The name, signature, & address must be of the student
- One parent or legal guardian must sign under "signature of parent"
- The witness signature must be signed and dated from someone 18 years of age or older. It cannot be from the same person that signed under "signature of parent". A neighbor, friend, relative, sibling, or other parent may sign as the witness. It **does NOT** have to be signed by a notary.

Consent for Treatment/Immunizations of a Minor Form (HEALTH FORM)

- **Do NOT** write in the box at the top that reads "For University Health Services Use Only."
- Complete the top section (Name of student, Date of Birth, Address, Phone). Leave the UTEID section blank.
- A parent/guardian must sign the box in the middle of this form that states "*I have received a copy of University Health Services Notice of Privacy Practices as required by HIPAA Privacy Rules*". The privacy practices form is available in this packet.
- Under "Medical Information related to Minor" please list any allergies, medications, or important medical history information of the student. If the student has not taken a Tetanus Booster leave that field blank.
- **Do NOT** include supporting documentation of immunizations received.
- There are **2 fields that require the parent signature on this form**. Both fields must be filled in order to provide health care by University Health Services.

THE UNIVERSITY OF TEXAS AT AUSTIN
RELEASE AND INDEMNIFICATION AGREEMENT - Minor

PARTICIPANT:

Name (last name first - please print or type) _____

Address _____

City, State, Zip Code _____

DESCRIPTION OF ACTIVITY OR TRIP: Un Sabado Gigante in Engineering

MODE OF TRANSPORTATION: (please circle one) School Bus or Personal Vehicle

LOCATION(s) of activity or trip: UT Austin Campus

DATE(s) of activity or trip: FROM November 14, 2009 TO November 14, 2009

I am the Parent/Guardian of the above-named Participant, who is under eighteen years of age and I am fully competent to sign this Agreement.

I give permission for Participant to participate in the above-referenced Activity or Trip. I acknowledge that the nature of the Activity or Trip may expose Participant to hazards or risks that may result in Participant's illness, personal injury or death and I understand and appreciate the nature of such hazards and risks.

In consideration of Participant being permitted to participate in the Activity or Trip, I hereby accept all risk to Participant's health and of his/her injury or death that may result from such participation and I hereby release the University of Texas at Austin, its governing board, officers, employees and representatives from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all illness or injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Activity or Trip, whether caused by negligence of the University of Texas at Austin, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the University of Texas at Austin and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity or Trip.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT'S INJURY OR DEATH OR DAMAGE TO PARTICIPANT'S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY OR TRIP AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT'S NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Signature of Parent/Guardian

Signature of Witness

Printed Name of Parent/Guardian

Printed Name of Witness

Address (if different from Participant's address)

Date signed: _____ 20____

The University of Texas at Austin

Media Release

CONSENT AND WAIVER

TO WHOM IT MAY CONCERN:

I hereby grant full permission to The University of Texas at Austin to prepare, use, reproduce, publish, distribute and exhibit my name, picture, portrait, likeness or voice, or any or all of them in or in connection with the production of web sites, still photography, motion picture film, television tape, film or sound track recording, scientific publication for informational or any other professional purpose deemed necessary in the interest of the mission of The University of Texas at Austin.

I hereby waive all rights of privacy or compensation, which I may have in connection with the use of my name, picture, portrait, likeness or voice, or any or all of them, in or in connection with said web sites, still photography, motion picture film, television tape, film or sound track recording and any use to which the same or any material therein may be put, applied or adapted by The University of Texas at Austin.

This consent and waiver will not be made the basis of a future claim of any kind against The University of Texas at Austin and any of its agencies.

IN WITNESS WHEREOF I have hereunto set my hand and seal this _____ day of _____ A.D. 2009.

NAME: _____

SIGNATURE: _____

ADDRESS: _____

SIGNATURE OF PARENT OR GUARDIAN*:

*When minor is recorded or when otherwise justifiable

WITNESS: _____

DATE: _____

FOR UNIVERSITY HEALTH SERVICES USE ONLY

Patient Name: _____

Medical Record #: _____

D.O.B.: _____ Gender: _____

Provider: _____ Date: _____

CONSENT FOR TREATMENT/IMMUNIZATIONS OF A MINOR

University-Sponsored Program Participant Information and Consent

Name of Program Participant: _____

UTEID (if one has been assigned): _____ Date of Birth: _____

Address (Street, City, State, Zip Code): _____

Parent/Guardian Phone Number: _____
HOME WORK / CELL

I, the undersigned, as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any an all claims and causes of action that my arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

PRINT NAME

I have received a copy of University Health Services *Notice of Privacy Practices* as required by HIPAA Privacy Rules.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

PRINT NAME

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

Please Return to Program Coordinator:

Name of Program: Equal Opportunity in Engineering Program (Un Sabado Gigante in Engineering)

Program Coordinator: Un Sabado Gigante in Engineering Coordinator

Coordinator's Phone: 512- _____ Coordinator's Fax: 512- _____

Coordinator's Mailing Address: _____

(Street) (City) (State) (Zip Code)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. HIPAA PRIVACY RULES REQUIRE THAT WE FURNISH YOU WITH THIS NOTICE. PLEASE REVIEW IT CAREFULLY.

- I. **Purpose:** University Health Services and its professional staff, employees, and volunteers follow the privacy practices described in this Notice. UHS maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, UHS must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, UHS must share your medical information as necessary for treatment, payment, and health care operations.
- II. **What Are Treatment, Payment, and Health Care Operations?**
Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medication, or with radiologist or other consultants in order to make a diagnosis. UHS may use your medical information as required by your insurer to obtain payment for your treatment. We also may use and disclose your medical information to improve the quality of care, e.g., for review and training purposes.
- III. **What Are Other Ways UHS May Use Your Medical Information?**
Your medical information may be used, unless you ask for restrictions on a specific use of disclosure for the following purposes:
- Appointment reminders.
 - To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
 - To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.
 - Worker's Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
 - Health oversight activities, e.g., audits, inspections, investigations, and licensure.
 - Certain research projects.
 - To prevent a serious threat to health or safety.
 - Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the results of criminal conduct; circumstances relating to reporting information about a crime.)
- IV. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose our medical information unless you authorize (permit) UHS in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.
- V. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by UHS.
- **Right to request restrictions.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency services.
 - **Right to confidential communications.** You may request communication in a certain way or at a certain location, but you must specify how or where you wish be contacted.
 - **Right to inspect and request a copy.** You have the right to inspect and request a copy your medical information regarding decisions about your care. We charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by UHS. UHS will comply with the outcome of the review.
- VI. **Requirements Regarding This Notice.** UHS is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. UHS may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at UHS for health care services, you may receive a copy of the Notice in effect at the time.
- VII. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with UHS or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to UHS or the Department of Health and Human Services.
- Contact: Call the UHS HIM Administrator at (512) 475-8432 if:**
- You have a complaint.
 - You have any questions about this Notice.
 - You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations.
 - You wish to obtain a form to exercise your individual rights described in paragraph V.