SOUTHERN
ADVENTIST UNIVERSITY
School of Nursing

CONSENT TO DISCLOSE MEDICAL INFORMATION

DIRECTIONS: Submit this form to the School of Nursing (see contact information below).

FIRST NAME	MIDDLE	LAST (FAMILY NAME)	BIRTH DATE MM-DD-YYYY	AGE

HOME ADDRESS	APT #	MEDICAL INSURANCE PROVIDER

CITY	STATE	ZIP CODE	EMAIL ADDRESS

PREFERRED PHONE NUMBER	ALTERNATE PHONE NUMBER	GENDER	MARITAL STATUS
		❍ Male ❍ Female	❍ Single ❍ Married

PREFERRED METHOD OF DISCLOSURE

I consent to the disclosure of my medical information (including immunizations, office visits, labs, x-rays, billing information, etc.) by the following means:

- ❑ Call my cell phone.
- ❑ Call my alternate phone.
- ❑ Leave a voicemail with detailed information.
- ❑ Leave a voicemail with call-back number only.
- ❑ Email me at the address above.
- ❑ Mail my information through the postal service to my home address.
- ❑ My spouse (please provide contact information:

SPOUSE NAME AND PHONE

PATIENT-INFORMATION-DISCLOSURE CONSENT

I, the undersigned student, do hereby affirm that the above information is accurate and complete. I authorize, in the case of illness or injury, any diagnostic or therapeutic examination, procedure, treatment, or transportation deemed advisable by and rendered under the supervision of the University Health Center practitioner, independent healthcare providers, selected by faculty, officers, or agents of Southern Adventist University or selected by the undersigned. In compliance with HIPAA Privacy Policies & Practices, consent is hereby granted to the University Health Center to release pertinent medical information to designated healthcare professionals for the purpose of evaluating health, diagnosing medical conditions, and providing treatment. I understand I may revoke this consent at any time by submitting a written statement.

I understand I am responsible for all charges incurred. I take financial responsibility for all non-covered services and co-insurance amounts. I give authorization to release any and all necessary information to my insurance company for the processing of a claim. I also authorize that payment may be made directly to the physician and healthcare providers. I understand that this information may be faxed through a non-dedicated, therefore, non-confidential, fax line.

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

PATIENT SIGNATURE

TODAY'S DATE

UPLOAD: Application Status Page

Mail to: Southern Adventist University • School of Nursing • PO Box 370 • Collegedale, TN, 37315-0370