Albany State University
Student Health Services
504 College Drive
Billy C Black RM 138
Albany, GA 31705
Office 229.500.3544 ♦ Fax 229.500.4918

Today's Date: _____ ASU ID #: 900_____

PATIENT INFORMATION

Patient Name:_____Birthdate:_____/_____/_____Age*:_____
Last First MI

*for students under 18 years of age, a parental or legal guardian authorization for medical treatment form must be on file in our office in order for you to receive prompt care and treatment should the need arise.

Sex: ☐Male ☐Female ☐Other Marital Status: ☐Single ☐Married ☐Divorced

Race: ☐Asian ☐Black ☐Multiracial ☐White ☐Hispanic ☐American Indian/Alaskan Native ☐Hawaiian/Pacific Islander

Permanent Home Address: _____

City:_____State:_____Zip Code:_____County: _____

Cell:_____Home Phone:_____Email: _____

Local Address or Residential Hall – Room # & ASU Box #: _____

City:_____State:_____Zip Code: _____

CONTACT INFORMATION

Emergency Contact:_____Relationship to you: _____

Home Phone:_____Cell:_____Mother's Maiden Name: _____

Consent to Treatment: I voluntarily authorize the rendering of such care, including diagnostic and medical treatment by authorized agents and employees of Albany State University Student Health Services (hereafter referred to as Student Health) and the medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

Release of Information: I authorize the release of my medical records or the records of the person for whom I am duly authorized to do so, of such medical and/or psychiatric information as may be required by:

1. Any health sickness, and accident insurance carrier, workman's compensation, or agency (social welfare, governmental) which is legally responsible, or which Student Health has good cause to believe is legally responsible for all or any part of the Medical Center's charges and/or professional fees.
2. Physicians or health care facilities rendering or evaluating the patient for professional care.
3. The Peer Review Organization responsible for reviewing medical care.

This consent may be revoked at any time, except to the extent that action has already been taken by the patient/duly authorized agent.

Guarantee of Payment: I agree to be responsible to Student Health for charges resulting from services rendered at their prevailing rates and not covered by the health fee.

University System of Georgia Board of Regents Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices: I have read and acknowledged the Board of Regents "Notice of Privacy Practices" for protected health information.

_____ _____
Patient Signature **Date**