Saint Xavier University (SXU) Health Center

FAX: 773-298-3906

3700 W. 103rd Street, Chicago, IL 60655
Telephone: 773-298-3712

Consent to Obtain or Furnish Patient Information

Patient Name: ______________________________________ Date of Birth: __________________

Address: ________________________ City: __________________ State: _____ Zip: _________

I hereby authorize SXU Health Center to **DISCLOSE** **(give a copy)** my confidential, protected health information to:	OR	I hereby authorize SXU Health Center to **OBTAIN** **(request a copy)** of my confidential, protected health information from:
□ SXU School of Nursing & Health Sciences □ SXU Dean of Students Office/Resident Life □ SXU Counseling Center □ Mercy Circle □ Other: Name: _____________________________ Fax Number: ________________________		Name: _____________________________ Fax Number: ________________________

Information Requested (choose all that apply):

- □ Name and contact information
- □ Dates of treatment
- □ Treatment recommendations/plans
- □ Treatment progress
- □ Diagnosis/Prognosis
- □ Prescriptions
- □ Medical Evaluation
- □ Lab/Pathology Reports
- □ Admission, Discharge or Progress Notes
- □ Immunization Records
- □ Reason for visit and/or referral
- □ Drug Screen Results
- □ Other____

Express Purpose for Disclosure (choose all that apply):

- □ Comprehensive evaluation and/or treatment
- □ Referrals/coordinating treatment
- □ SXU support services
- □ Student program participation requirements
- □ Employment requirement
- □ Other: ____

Authorization:

I understand the risks and procedures involved with using electronic communication to request and obtain protected health information. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail and facsimile as one form of communication with my physician, and his/her associates, technicians and other health care workers.

Duration of Consent and right of Revocation: I understand this authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. This authorization form is valid until one year after signing, unless otherwise specified. I reserve the right to revoke the consent at any time. I understand that SXUHC may not condition treatment or payment upon my executing this authorization. In an emergency situation where I am lacking the capacity to give informed consent, when a delay in treatment could result in serious disability or death; I understand that my patient information may be disclosed or obtained as necessary to the appropriate officials who are seeking to address my needs to protect my health and safety.

____ ____________________

Signature of Patient or Parent/Guardian (if <18 years old) Date

If Parent/Guardian – relationship to patient:_________________________