SXU Health Center

3700 W. 103rd St
Chicago, IL 60655
Phone (773) 298-3712
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healthcenter@sxu.edu

Voluntary Disclosure of Medical Condition(s)

Name of Student_____ D.O.B._____

Please describe the medical condition(s) you wish to disclose (including information such as year of diagnosis, factors that make the condition better or worse, current medications taken (name, dose, frequency), drug/food/environmental allergies, treating provider with phone number, etc). Continue on the back if more space is needed:

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All medical conditions disclosed on this form will be held in strictest confidence at the SXU Health Center and in accordance with all applicable federal and state laws and regulations, including HIPAA. This form is meant only to provide information to the healthcare providers at the SXU Health Center in the event that the named student requires medical attention at the Health Center; it is not meant to provide diagnosis and treatment or to take the place of a medical visit.

By my signature below, I confirm that the information herein has been provided voluntarily by me or my duly authorized representative. I further authorize healthcare providers at the Health Center to review this information for the purpose of determining the nature and scope of services that may be offered at the Health Center, or may be required to be performed by professionals at authorized medical care facilities. I further understand and acknowledge that review of this information may be done only by those authorized under applicable federal and state laws and regulations.

Signature of person filling out form _____ Date _____

Relationship to student_____

Phone number the student can be reached if there any questions about this form_____

<u>Mail, fax, e-mail, or drop off</u> this form at the SXU Health Center. Please call us with any questions.