ERAU Wellness Center
HIPAA Form
Confidential Communication Request and Patient Notification Process

Patient Name:_____

Student ID#:_____

DOB:_____

Phone#:_____

☐ **Permission to call the above number to leave messages regarding tests results and appointments**

☐ **Permission to receive text reminders for appointments**

Please read and initial the following statements:

_____I hereby authorize release of information required by treating physicians, counseling department, athletic trainers, ____Dean of Students office, ____ faculty, _____ROTC,_____ flight line, ___and insurance carriers for the above named patient.

_____I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange(HIE).I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

_____ I understand that visits to outside facilities are not paid for by the Wellness Center. I also understand that I am responsible for the payment of any tests sent to outside laboratories.

_____I understand I may receive a copy of the Privacy Rules from the ERAU Wellness Center, if requested. I hereby authorize the Wellness Center and/or their representatives to discuss my medical care information with the persons listed below. I may revoke this at any time by giving written notification to the ERAU Wellness Center.

Permission to give verbal protected health information to the following person(s):
Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Signature:_____ Date:_____