THE UNIVERSITY OF ALABAMA® | Student Health Center *and* Pharmacy

VERBAL COMMUNICATION

Request & Authorization for Verbal Communication of Protected Health Information

CWID: _____ Date of Birth: _____

Patient Name: _____ Patient Telephone: _____

Permanent Address: _____

_____

Person authorized to communicate with: _____

Relationship to patient: _____

# of discussions authorized (**initial only one**): 1. Once: _____ **and** Specify Date: _____

2. Unlimited: _____

3. Time Frame: _____ **and** From: _____ To: _____

Areas of Communication: I authorize discussion of the specific categories of information.

INITIAL EACH CATEGORY

Treatment Plan:	YES_____	NO_____
STD Test Results:	YES_____	NO_____
Prescription Medications:	YES_____	NO_____
Over the Counter Medications:	YES_____	NO_____
Billing Information:	YES_____	NO_____

I may withdraw this authorization at any time. This authorization is only valid for the time specified in this authorization. In the event of an emergency situation, the Health Care Provider will notify appropriate parties.

I AUTHORIZE the release of information by verbal discussions as noted above by my initials:

Signature: _____ Date: _____

Witnessed by: _____ Title: _____ Date: _____

I DENY consent for any verbal communication:

Signature: _____ Date: _____

Witnessed by: _____ Title: _____ Date: _____

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PATIENT CONSENT/RESPONSIBILITY FORM

Name: _____ **CWID**_____ **DOB**_____

Thank you for choosing the University of Alabama Student Health Center (SHC) for your medical needs. We ask that you read and sign this form to acknowledge your understanding of your rights and responsibilities. If you have ANY questions, please ask one of the receptionists.

Please initial boxes:

☐ **CONSENT FOR TREATMENT:** I consent to and authorize my health care provider to treat me. I understand this could include lab tests, x-rays, education or other diagnostic procedures. I understand my provider is available to explain my treatment, and that I have the right to refuse treatment.

☐ **CHAPERONE:** I understand that a chaperone will be provided for a sensitive exam and further understand I may request one for any visit and it will be accommodated.

☐ **ASSIGNMENT OF BENEFITS:** I authorized payment for medical services provided directly to SHC. I understand that any charges my Health Insurance Plan does not authorize will be charged to my student account. I authorize SHC to release to my Health Insurance Plan such medical information needed to determine these benefits or the benefits payable for related services.

☐ **PATIENT RESPONSIBILITY:** I acknowledge that I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. I acknowledge that I am responsible for obtaining prior authorization or referrals for my services. I acknowledge that I am responsible for all charges for services provided and understand that all charges not covered by my Health Insurance Plan will be charged to my student account.

☐ **PATIENT PRIVACY NOTICE:** I acknowledge that I have been given the opportunity to review the SHC Privacy Notice and Patient Rights and Responsibilities Statement which is posted at the front desk and on line at www.shc.ua.edu , that I am entitled to have my own personal copy of the Privacy Notice, and that SHC has made available a copy of this document for me to have.

I have read, understand, and agree to the provisions listed above:

Signature of Patient_____ ***Date*** _____

Designee of the SHC_____ ***Date***_____

OR WAIVER OF PATIENT AUTHORIZATION: I do not wish to have information released to my Health Insurance and prefer to have my charges for ***DOS:***_____ sent to my student account and be fully responsible for my charges. Submitting claims to my Health Insurance will be at my discretion.

Signature of Patient_____ ***Date*** _____

Designee of the SHC_____ ***Date***_____

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Tuscaloosa, AL 35401
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AUTHORIZATON TO DISCLOSE HEALTH RECORDS

Print Patient's Legal Name_____

Birth date _____ **CWID**_____

To all physician, hospitals, clinics, and any other medical facilities. I hereby authorize the disclosure of my individually identifiable protected health information ("PHI") as described below to the **University of Alabama Student Health Center**. Unless explicitly excluded, this Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary.

I hereby authorize the disclosure of my individual identifiable protected health information to myself.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this authorization will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete this request.

Information to be faxed: _____

Patient Signature: _____

Date: _____

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Billing for Non-Covered Services

Or

Covered services that the patient has opted out of submitting to the health insurance carrier

Patient Name	CWID	Date

It is our goal to provide you the best care possible. There are services or durable medical equipment and supplies that may be provided for the treatment of your condition, and deemed necessary by your provider, that may not be covered by your health benefits insurance contract. You are expected to pay for those services in full.

Additionally, if you have requested services and chosen to not have the provided services submitted to your health insurance carrier for payment, you are expected to pay for those services in full.

These charges will be billed to your student receivables account.

*Services that may not be covered include, but are not limited to:

Durable Medical Equipment and Supplies

Visits to screen for Sexually Transmittable Infections

Women's Health

Behavioral Health

Immunizations

Allergy Treatment

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. You can also contact your insurer' Customer Service Department at the number on the back of you ID card. Thank you for understanding.

Consent obtained by: _____

I have read the above policy and agree to pay for the services not covered by my health benefits insurance contract, or not submitted to my health insurance carrier at my request, as indicated by my signature.

Signature of Patient (no initials please): _____

Revised: February 2017

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TELEMEDICINE INFORMED CONSENT

I _____ [name of Patient] hereby consent to engaging in telemedicine with _____ [name of Provider] as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Alabama or outside of Alabama.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of health services (e.g. face-to-face services) I will be referred to a provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my provider, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Alabama law.

I have read and understand the information provided above. I have discussed it with my provider, and all my questions have been answered to my satisfaction.

_____ _____

Signature of patient Date

Created: 08/2020