SXU Health Center

3700 W. 103rd St
Chicago, IL 60655
Phone (773) 298-3712
Fax (773) 298-3906
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:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

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.