INTAKE AND CONSENT FORM FOR HEALTHCARE PLANNING SERVICES (HIPPA AUTHORIZATIONS)

Full Legal Name: _____ **Date:** _____
Date of Birth: _____ Student ID #:_____
Primary telephone number: _____ Email address: _____
Mailing address: _____

I am interested in: ☐ HIPPA Releases ☐ Power of Attorney for Healthcare ☐ Other

How did you hear about us?

☐ Friend ☐ OU Daily ☐ Class Presentation ☐ OU department: _____
☐ Internet search ☐ OU Staff member ☐ On-Campus event ☐ Other:_____
☐ OU Email ☐ Poster / Ad ☐ Parents

How do you identify yourself? Please choose as many boxes from each line as necessary:

1.) ☐ Male ☐ Female ☐ Non-binary ☐ Other

2.) ☐ In-state student ☐ Out-of-State Student ☐ International Student ☐ Health Science Center

3.) ☐ American Indian / Alaskan Native ☐ Asian / Pacific Islander / Desi-American
☐ Black or African-American ☐ White or Caucasian ☐ Latinx/a/o
☐ Middle Eastern ☐ I prefer to not disclose ☐ Other: _____

I, the undersigned, hereby affirm that I am a currently enrolled student at the University of Oklahoma. I understand that the legal services offered by the University of Oklahoma Student Legal Services program (SLS) are limited in nature. I understand that the attorney-client relationship created by my use of the SLS program is a short-term, non-continual, transactional relationship that does not extend beyond in office attorney consultation(s). Being fully aware of these limitations, I consent to the limited scope of representation provided by SLS. I have been advised by SLS that I may need to seek further assistance of counsel. I am aware that the SLS attorney is not paid for directly by me, but by the University of Oklahoma, a third-party payor. Being fully aware of this payment arrangement, and the other limitations addressed herein, I hereby provide my consent to such representation. **I am aware that the SLS attorney cannot guarantee the confidentiality of emails sent or received on the university server. _____ (initial)**

I, _____, understand that a HIPAA Authorization is a waiver of liability that allows a medical record holder to disclose protected health information (PHI). A HIPPA authorization allows doctors, nurses, hospitals, laboratory technicians, and other health care providers to disclose my private medical information, such as X-rays, laboratory and pathology reports, diagnoses, prescriptions, and other health information, without any legal liability for disclosing the information in accordance with the authorization. I understand that authorizing the disclosure of my private medical records is a completely voluntary decision. I understand that once granted, the permission to disclose PHI is broad. This means that virtually any of my private medical records can be disclosed to the person(s) listed. This could include personal information related to prescription and non-prescription drug use (legal and illegal), use of birth control, treatment for sexually transmitted disease, etc. Being fully aware of the ramifications of a HIPPA Authorization, I affirm that I am executing the Authorization as my knowing and voluntary act and deed.

_____
Student Signature