STUDENT LEGAL SERVICES HEALTHCARE PLANNING INTAKE AND CONSENT FORM

Full Legal Name: ____Date of Birth:__________________

Email:____ Student ID:____________________

Home address: ____

I, ____, 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, transactional relationship that is non-continual and does not extend beyond the services I have received. Being fully aware of these limitations, I consent to the limited-scope representation provided by SLS. I have been advised 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 services. ***I have been advised that the SLS attorney cannot guarantee the confidentiality of emails sent or received on the university server.***

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Student Signature, Date

Further, I affirm that I am voluntarily seeking healthcare services, specifically a Power of Attorney for Healthcare (POAHC), and that:

1. I am 18 years of age or older. _____________ (initial)
2. I am competent and capable of making decisions for myself regarding my healthcare and other matters affecting my best interests. _____________ (initial)
3. I have been offered a copy of the Oklahoma Instructions for the Healthcare Power of Attorney and have read and understand them. _____________ (initial)
4. I want to nominate another person to make healthcare decisions for me in the event that I become incapacitated, and am no longer capable of making or communicating informed decisions about my own care. _____________ (initial)
5. I understand that my agent will have the authority to consent or refuse consent on my behalf for any care, treatment, service, or procedure affecting my health, including signing a DNR (do not resuscitate) form. _____________ (initial)
6. I understand that I may revoke or amend my Power of Attorney for Healthcare in writing at any time. _____________ (initial)

7. Once completed, I understand that it is my responsibility to provide copies of my POAHC to my physician and to any other health care providers I may have, to any health care facility at which I receive care, and to the health care agents I have named. _____________ (initial)

Finally, with regard to waiving privacy protections (HIPAA releases) as to my protected health information (medical records):

I, ____, understand that:

1. A HIPAA Authorization is a waiver of liability that allows a medical record holder to disclose protected health information (PHI). **It allows doctors, nurses, hospitals, laboratory technicians, and other health care providers to share my private medical information**, such as X-rays, laboratory and pathology reports, diagnoses, prescriptions, and other health information in accordance with the authorization without any legal liability for having shared or disclosed.

2. I understand that **authorizing the disclosure of my private medical records is not required and is a completely voluntary decision.**

3. Once submitted, I understand that virtually any of my private medical records can be disclosed to the person(s) listed. The permission to disclose PHI is broad. **This could include personal information related to mental health care, prescription and non-prescription drug use (legal and illegal), usage or non-usage of birth control, treatment for sexually transmitted disease, pregnancy status, etc.**

- ○ I wish for all of my Protected Health Information to remain confidential and am therefore not interested in HIPAA releases at this time,

-or-

- ○ I want to grant permission to my healthcare providers for my Protected Health Information to be disclosed as indicated on their forms and request that Student Legal Services provide HIPAA releases recommended for use in the State of Oklahoma.

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Student Signature, Date