



Valdosta State University
 Student Health Center
 Valdosta, GA 31698

REGISTRATION RECORD

It is important that you use ink, print, and fill out this form completely.

Patient Name (Last, First, Middle)	Emergency Phone	
	Emergency Contact and Relationship	
Local Address (street, city, state, zip code)	VSU ID Number	
	Date of Birth (month, date, full year)	
Campus/Local Phone		
Work/Day phone	Major (e.g.: History, Fine Arts, Undeclared)	
Home/Permanent Address (if different)	Race (Circle One) Asian Black Multiracial White Hispanic American Indian/Alaskan Native Hawaiian/Pacific Islander	
Home/Permanent Phone	Marital Status: (Circle One)	SEX:
	Single Married Divorced	M F
Mother's Maiden Name Only	Father's First Name	

Consent to Treatment: I voluntarily authorize the rendering of such care, including diagnostic and medical treatment by authorized agents and employees of Valdosta State University Student Health Center (hereafter referred to as Student Health) and the medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

Release of Information: I authorize the release of my medical records or the records of the person for whom I am duly authorized to do so, of such medical and/or psychiatric information as may be required by:

1. Any health sickness, and accident insurance carrier, workman's compensation, or agency (social welfare, governmental) which is legally responsible, or which Student Health has good cause to believe is legally responsible for all or any part of the Medical Center's charges and/or professional fees.
2. Physicians or health care facilities rendering or evaluating the patient for professional care.
3. The Peer Review Organization responsible for reviewing medical care.

This consent may be revoked at any time, except to the extent that action has already been taken by the patient/duly authorized agent.

Guarantee of Payment: I agree to be responsible to Student Health for charges resulting from services rendered at their prevailing rates and not covered by the health fee.

Patient Signature

Signature of Witness

Date

Patient Signature

Signature of Witness

Date

Patient Signature

Signature of Witness

Date