STUDENT HEALTH & WELLNESS CENTER

Student ID #: _____ Date: _____

Last Name: _____ First Name: _____ Initial: _____

Address: _____City, State, Zip_____

Telephone: _____ Birth Date: _____ Sex: ☐ M ☐ F

Email:_____ _____

Health Insurance:_____ Medi-Cal: _____Yes _____No

If Yes, ID#_____

EMERGENCY CONTACT:

Name: _____ Telephone #:_____ Relationship: _____

Medication Allergies: _____

Reason for Visit: _____

COLLEGE OF THE CANYONS
STUDENT HEALTH & WELLNESS CENTER

Date: _____

Name:_____ Student ID #:_____

Emergency Contact:

_____ _____ _____
Name Phone # Relationship

Personal History:

1. Medication Allergies: _____

2. Medications used regularly: (i.e. thyroid, birth control, insulin, etc.):

   _____

3. Any regular use of alcohol, Marijuana, sleeping pills, street drugs, or tranquilizers?

   _____ If yes, please identify: _____

4. Do you smoke?_____ How many per day?_____

5. Past **major** medical illnesses, accidents, surgeries?

   _____

6. Any physical handicaps? (i.e., vision, hearing, etc.) Please describe:

   _____

7. Do you have a personal physician? _____

   Name:_____Phone:_____

8. Do you have health insurance? _____

   Name:_____

9. Any other health issues or concerns? Please list:

   _____

   _____

   _____

   _____

COLLEGE OF THE CANYONS

STUDENT HEALTH & WELLNESS CENTER

GENERAL CONSENT TO TREAT

The undersigned patient and/or responsible relative or person hereby consent to and authorize College of the Canyons' Student Health & Wellness Center physicians and medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, vaccinations and immunizations against disease which may be now or during the course of the patient's care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the patient for medical care relative to continuity of care for this visit.

Date: _____

_____	_____	_____
Signature of Witness	Signature of Patient	Name of Patient

_____	_____	_____
Signature of Witness	Signature of Responsible Relation or Person	Name of Responsible Relation or Person

COLLEGE OF THE CANYONS

Student Health & Wellness Center
Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

1. This practice may use or give out your health information for the following reasons:

   Treatment:
   We give information to those involved in your care. Our staff, specialists we refer you to, pharmacists, lab personnel, as appropriate.

   Payment:
   We give out information to get paid for our services from funding sources and/or programs that you may be enrolled in to receive benefits. (FamilyPACT and/or Student Accident Insurance)

   Health care operations:
   - Quality Assurance programs to improve our services
   - Audits by agencies funding our operation or providing benefits
   - Insurance companies to authorize services or referrals
   - Business associates as appropriate (nutritionist/mental health providers, nurse practitioners, RN, athletic trainers, etc.
   - Applications for programs/agencies designed for your specific needs
   - Contacting you. Appointment reminders, messages for follow-up exams or lab results, etc. at the contact information you provide
   - We will call your first name when the provider is ready to see you
   - Federal or state government auditing privacy practice compliance
   - Gathering health or demographic information for statistical purposes that can not be traced back to you.

2. The health center will not use or give out health information for any reason not listed without your written authorization. You can revoke this authorization at any time.

3. The health center is required to give out health information **without your consent** in two circumstances: Required by law or public health.

4. The health center will abide by the terms of this notice but reserves the right to change the terms when necessary and provide any changes to you at the next visit. Copies of this notice will be posted in the waiting room and provided on request.

Privacy Rights

As a patient of the Student Health & Wellness Center you have the right to:

- Ask us not to share the health information in the ways described in the privacy notice. This will affect any programs you are entitled to and we may not be able to agree with your request.
- Ask us to contact you only in writing or at a different address or phone number. We will accept reasonable requests to protect your safety.
- To see a copy of your medical record. Written requests for specific information must be provided with 72 business hour notice. You may be charged a fee for copying or mailing. We may keep you from seeing all or part of the record for reasons allowed by law. Including your mental health record.
- Change the record if you believe some information we have about you is wrong. If your change request is denied, a copy of your letter will be kept in the record.
- You have the right to withdraw or revoke your authorization. If you revoke your authorization, it is only effective after the date of your written revocation, or withdrawal using the designated form.

If you want these rights explained or if you wish to file a complaint about the health center not protecting your privacy please contact:

Director, Student Health & Wellness Center
26455 Rockwell Canyon Road
Santa Clarita, CA 91355
(661) 362-3259

Or:

Secretary of the Department of Health & Human Services by writing to:
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877)696-6775

No Action will be taken against anyone whom files a complaint.

Date:_____ Print Name:_____

Signature: _____

- A copy can be provided to you at any time by request.