BRIGHAM YOUNG UNIVERSITY

STUDENT HEALTH CENTER

CONSENT TO RELEASE WELLNESS TRIPLE SCREENING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Please Print *MM/DD/YYYY*

Employee Name: _____ BYU ID#: _____
Please Print

I, _____ authorize the Brigham Young University Student Health Center
***Patient** Name*
and its employees and agents to draw my blood for the purpose of running the BYU Wellness Program Triple Screening blood test, to process the blood screening, and then to transmit the results to me in the following manner:

☐ Send my results to the following email: _____

☐ Send my results by campus mail to the following campus address: _____

I realize that email may not be a secure method of delivery. I understand that the information released in any of these manners may no longer be protected by federal and state privacy laws. I further understand that this authorization is voluntary and that I may decline to sign this authorization if I decide not to receive my triple blood screening results.

This authorization is valid from the date of my signature below and shall expire immediately after the Student Health Center Records Office successfully sends my personal health information to me in the manner I indicated on this form or, if unsuccessful, by such alternate manner that I provide hereafter in writing.

PAYMENT AND PRIVATE INSURANCE AGREEMENT: I understand and accept my financial obligations to compensate the SHC for medical services provided to Patient. The SHC may not be contracted with some insurance companies. However, I understand that when I bring my insurance card to my appointment, and if the SHC is contracted with my insurance, the SHC will bill my insurance company. I also understand that all charges will be sent to the BYU employee's "myBYU" financial account, whether my insurance company is contracted with the SHC or not, and that the employee is ultimately responsible for the payment.

Signature of Patient: _____ Date: _____
MM/DD/YYYY