ANANDA UNIVERSITY
GAP YEAR PROGRAM MEDICAL FORM

Name:
Contact info, etc.
Emergency contact:

Health Insurance Info:
Name Address
Policy Holder: Policy Number:
Does your insurance company require primary care physician authorization for referral to specialists?
Primary Care Physician (Contact)

This completed medical questionnaire is required of all participants in the Ananda University Gap Year program. It must be received at least (3) weeks before the start of the program. Acceptance into the program cannot be given until a complete medical form is provided. This information is CONFIDENTIAL and will not be released to anyone without your knowledge and consent. We do need to know who has the authority to make health care decisions on your behalf and is authorized to receive or view healthcare info and documents pertaining to you. [Please complete HIPAA form below].

Do you have any condition that limits your physical abilities?

Has your academic or work career been disrupted by any physical or emotional issues? If so, please explain.

Have you ever had any serious illness or injury? (If so, please explain.)

Please identify any allergies or allergens you may have (environmental, food, medication, etc.)

Please list any medications (prescription & nonprescription) you use.

Do you have problems or have you had problems with any of the following?

Diabetes____	Asthma____	Depression ____
High Blood Pressure____	Seizures____	Chemical or other substances ____
Chronic Headaches___	Cancer _____	Over/Under Weight _____
Ulcers ____	Dizziness _____	Allergies or Sensitivities _____

Please identify any other condition thatmay impact or be important for your health care.
_____

_____

I have personally supplied the information required by this Medical Questionnaire. It is true and complete to the best of my knowledge. I understand that this information is STRICTLY confidential and will not be released without my written consent unless otherwise permitted by law.

I authorize the Ananda University Gap Year program staff to share my medical information with [Name(s) on HIPAA Privacy Form during my enrollment with the Gap Year program with: (relationship – parent, spouse, relative, friend, etc.)

Authorized Person: _____ Relationship: _____

Accidents are the leading cause of death for young adults, and a quarter-million Americans between 18 and 25 are hospitalized with nonlethal injuries each year. We need to know **Who has the authority to make health care decisions on your behalf. We also recommend that you have and provide us with a Health Care Proxy.**

HIPAA Privacy Authorization Form

AUTHORIZATION:
I authorize the designated_____ (healthcare provider) or any healthcare provider to use

and disclose the protected healthcare described below to _____ (individual seeking

information).

EFFECTIVE PERIOD:
This authorization for release of information covers the period of healthcare from _____ to

_____.

OR

- € All past, present and future periods.

3. EXTENT OF AUTHORIZATION:

a. I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV, AIDS. and treatment of alcohol or drug abuse.

-OR-

b. I authorize release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (incuding HIV and AIDS)
- Alcohol/Drug abuse treatment
- Other (please specify) _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage for the insurer as a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of authorizing individual or patient

_____
Personal Representative and his/her relationship to individual or patient