FLORIDA BIBLE COLLEGE OF TAMPA

Health Service Record

Applicant

Last Name, First Name, Middle Name DOB

☐ Male ☐ Female

History (Gives Dates as close as possible)

Measles	Mumps	Chicken Pox	Epilepsy	Diabetes	Neurosis	Rheumatic Fever
☐	☐	☐	☐	☐	☐	☐

Whooping Cough	Scarlet Fever	Tuberculosis	Contact w/ TB	HIV/AIDS	Other Contagious Disease (specify)
☐	☐	☐	☐	☐	☐

Allergies	Surgeries (specify)	Recent Serious Illnesses
☐	☐	☐

Recent Physical Examination: **Date:**

Height	Weight	Posture	Skin	Eyes	
				Right	Left

Ears		Nose	Teeth	Pharynx	Lymph Nodes
Right	Left				

Chest	Heart		Blood Pressure	Pulse	Abdomen
	Rhythm	Murmurs			

Hernia	Pelvis	Spine	Feet	(Female Only) Menstrual Difficulties
	Time Lost Due to Menstrual Difficulties			

Observed Mental and Emotional Stability

Any Limitation of Participation in Physical Activities

Lab Work

Urinalysis	Wassermann or Kahn	Hemoglobin	Any recent x-ray?	TB Skin Test	Polio
Immunization (Date)					

Physician's Certification:

I certify that I have carefully examined this applicant and have correctly recorded the results. To the best of my knowledge the subject is free from all communicable disease and is in sound mental and physical health.

Date	Signature	Printed Name	Address

Note to Physician: It is requested that this report be forwarded directly to the Registrar, Florida Bible College of Tampa, 4811 George Road, Tampa, FL 33634, by theexamining physician. To be valid, this report must be completed on the basis of an examination and laboratory work done within six months of the registration date ofthe semester for which it is submitted. All medical information will be held in the strictest confidence. This health record is an essential part of the applicant's registration. Failure to provide it may result in rejection of the application and at the least will result in a late registration fee with a financial penalty.

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IVof this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:Tick as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses,lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information ☐ Mental health records ☐ Communicable diseases including, but not limited to, HIV and AIDS ☐ Alcohol/drug abuse treatment records ☐ Genetic information ☐

Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal ☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request forsharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to beshared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to furthershare the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From_____to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at anytime and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I amentitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature:_____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf,such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____