University of Kentucky Health Service
Lexington, Kentucky

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)	**SOCIAL SECURITY NUMBER**
	DATE OF BIRTH (month, date, full year)
CAMPUS/LOCAL PHONE	**SCHOOL ATTENDING** (Circle one) UK LCC Non-Student
WORK/DAY PHONE	**COLLEGE** (e.g.: Law, Fine Arts, Undeclared)
HOME/PERMANENT ADDRESS (if different)	**RACE** (Circle one) **A**sian **B**lack **M**ultiracial **W**hite **H**ispanic **A**merican Indian/Alaskan Native **H**awaiian/Pacific Islander
HOME/PERMANENT PHONE	**MARITAL STATUS**: (Circle One) Single Married Divorced | **SEX:** **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 University of Kentucky Health Service (hereafter referred to as UHS) and/or UK Healthcare, 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 UHS 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 UHS for charges resulting from services rendered at their prevailing rates and not covered by the UHS health fee.

✕ Patient Signature	Signature of Witness	Date
Patient Signature	Signature of Witness	Date
Patient Signature	Signature of Witness	Date
Patient Signature	Signature of Witness	Date
Patient Signature	Signature of Witness	Date
Patient Signature	Signature of Witness	Date