



Name (please print): _____

ID#: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Biola University Student Health Center values the privacy of its patients and the confidentiality of the personal and health information entrusted to us. In order to protect this privacy, we have policies and procedures to limit disclosures of Personal Health Information (PHI) to those necessary for the medical care of our patients, those for which the patient has given permission and/or those required by law or public safety, and in certain emergency situations.

Biola University Student Health Center originates, records, and maintains health information describing patients' health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. This health information may be used or disclosed by Biola University Student Health Center for treatment, payment, and healthcare operations. The Health Center, when necessary, may use your health information in the following ways:

- As a basis for planning your care and treatment;
- As a means of communication between other healthcare professionals who may assist in your medical care;
- As a source of information to create a bill for healthcare services rendered;
- As a means by which a third-party payer can verify that services billed were actually rendered;
- As a tool for routine healthcare operations, such as assessing quality of healthcare operations and utilization review.

You have the right to

- Request restrictions as to how your healthcare information may be used or disclosed in order to complete treatment, payment or healthcare operations. Biola University Student Health Center is not required to agree to the restrictions requested.
- Revoke this Consent in writing except to the extent that Biola University Student Health Center has already taken action in reliance upon the Consent.
- View or request copies of your medical information. A fee may be charged for copying medical records.
- Receive confidential communications concerning your medical condition and treatment
- Request amendment or submit corrections to your medical information
- Receive an accounting of how and to whom your medical information has been disclosed
- Receive a printed copy of this notice

If we make a change in our privacy practices, we will make the new notice available upon request.

We will not use or disclose your health information without your authorization, except as described in this notice.

I request the following restrictions to the use or disclosure of my health information from the list above: _____

I give access to my medical records to the person(s) listed below and for the time period stated below.

Name _____ Effective dates _____ until _____

Name _____ Effective dates _____ until _____

Name _____ Effective dates _____ until _____

Name _____ Effective dates _____ until _____

By signing this form, I consent to Biola University Student Health Center's use and disclosure of my health information for treatment, payment, and healthcare operations as listed above. Any other use of my personal health information must have my written consent before disclosure to any person.

Signature of Patient: _____ Date: _____

Signature of Parent or Legal Guardian if under 18: _____ Date: _____