



University Health Center

SOUTHEASTERN LOUISIANA UNIVERSITY

MEDICAL CONSENT: THIS SECTION GIVES US PERMISSION TO TREAT YOU

I grant permission to the University Health Center physicians, nurse practitioners and nurses to render treatment or other medical care that might be deemed necessary to my health and well-being. When necessary for executing such care, permission for hospitalization at an accredited hospital is granted. I understand that I am responsible for personal expense not provided by the University Health Center. Failure to execute this form will relieve the University from any liability.

I am aware that the University Health Center charges for some services. I accept personal responsibility for the payment of incurred charges at the time services are rendered.

Patient Signature

W_____
I.D. Number

NOTICE OF PRIVACY PRACTICES

This section says your information here is private and we aren't to give it to anyone unless you ask us to!

This notice of privacy practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how medical information about you may be used and disclosed and how you can get access to your medical information. This is a brief description of the privacy statement. To read the entire policy with detailed explanations, ask the clerk or nurse to provide you with the entire policy to read and review.

The University Health Center may use your protected health information for purposes of providing treatment and conducting health care operations. Your health information may be used or disclosed only for these purposes unless the University Health center has obtained your authorization or disclosure is otherwise permitted by HIPAA or required by state law. Disclosures of your health information for the purposes described in this notice may be made in writing, orally or by FAX.

Federal privacy rules allow us to use or disclose your health information without your permission or authorization for a number of reasons including the following:

1. When legally required by federal, state, or local law,
2. When there is risk to the public health,
3. To report abuse, neglect or domestic violence,
4. To assist in health oversight activities; and
5. In conjunction with judicial and administrative proceedings.

We may choose to disclose your health information to a family member or close personal friend if it is directly relevant to the person's involvement in your care. You may object to these disclosures. Other than as stated above, we will **NOT** disclose your personal health information other than with your written authorization. You may revoke your authorization in writing at any time.

You have the following rights:

1. The right to inspect and copy your health information,
2. The right to request a restriction on uses and disclosures of your health information,
3. The right to request to receive confidential communication from us by alternative means or at an alternative location,
4. The right to have your health provider amend your health information and,
5. The right to obtain a paper copy of this notice.

NOTICE AND ACKNOWLEDGEMENT: I acknowledge that I have read the above Notice of Privacy Practices.

Patient Signature

Date