CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide you information about how Student Health Services can use or disclose your medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent.

By signing this Consent form, you: (1) Acknowledge that a copy of the NPP has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_____ _____
Patient's Name (Printed) KUID

_____ _____
Signature of Patient or Personal Representative Date

Personal Representative's relationship to Patient:_____

Personal Representative's Address and Phone Number:

_____
_____
_____
_____

PLACE LABEL HERE

PLEASE DO NOT WRITE BELOW THIS LINE

DOCUMENTATION OF GOOD FAITH EFFORT

Check the applicable box showing Good Faith Effort.

- ❑ Emergency situation. Provide patient with copy of NPP as soon as reasonably practicable after the emergency treatment situation.
- ❑ Patient/Legal representative given NPP, but declines to acknowledge receipt.
- ❑ Patient/Legal Representative states that they have already received the NPP.
- ❑ Other: _____

_____ _____
Employee Name (Printed) Date

_____
Signature of Employee