Consent for the Use of the Health Information for Treatment and Healthcare Operations

I understand and acknowledge that as part of my health care, The Master’s College Health Center originates, records, and maintains health information about me describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand and acknowledge that this health information may be used or disclosed by The Master’s College Health Center for treatment and healthcare operations. The Health Center will use your health information in the following ways:

- A basis for planning my care and treatment;
- A means of communication between other healthcare professionals who may assist in my medical care;
- A tool for routine healthcare operations, such as assessing quality of healthcare operations and utilization review

I acknowledge and understand that:

- The Master’s College Health Center has a Notice of Privacy Practices (HIPAA Law), which gives a more complete detailed description of healthcare information and disclosures which I have a right to review. I may request this document at any time.
- The Master’s College Health Center reserves the right to change the Notice of Privacy Practices and its policies and prior to implementing such as change, The Master’s College Health Center will mail a paper copy of any revised Notice of Privacy Practices to the address I have provided.
- I have the right to request restrictions as to how my healthcare information may be used or disclosed in order to complete treatment, payment or healthcare operations.
- The Master’s College Health Center is not required to agree to the restrictions requested.
- I may revoke this Consent in writing except to the extent that The Master’s College Health Center has already taken action in reliance upon the consent.
- In case of emergency or threat to student’s safety, a student’s healthcare information can be provided to the VP student Life and/or the Deans.

By signing this form, I consent to The Master’s College Health Center’s use and disclosure of my health information for treatment and healthcare operations as listed above. Any other use of my personal health information must have my written consent before disclosure to any person.

- I allow the restricted use of my health information as stated above.
- I requested the following restrictions to the use of disclosure of my health information from the list above:

_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

Signature of Patient: ___________________________________________ Date: __________________________

Signature of Parent or Legal Guardian: _____________________________ Date: __________________________ (if under 18)

For Office Use Only: Please Initial

☐ No Restrictions Listed _____  ☐ Restricted Accepted _____  ☐ Restrictions Denied _____