Baylor University Health Center (STUDENT)

Privacy Notice & Consent for Disclosure of Health Records and Information

I understand that as part of the provision of health care services, Baylor University Health Center creates and maintains health records and other information describing among other things, my prescription drug history, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

By signing this form, I consent to the use and disclosure of all medical records maintained by the Baylor University Health Center and my protected health information for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and will only be disclosed for the purposes of treatment, payment or health care operations and as otherwise provided by the Family Educational Rights and Privacy Act (FERPA) and other applicable law.

2. A photocopy or fax of this consent is as valid as this original.

3. I have the right to request that the use of my health records and protected health information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Baylor University Health Center and I must agree to any restriction in writing that I request on the use and disclosure of my health records and protected health information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(NAME PRINTED) DATE

_____ _____

SIGNATURE (OR GUARDIAN, IF A MINOR) BAYLOR ID#

CONSENT FOR TREATMENT

I authorize the Baylor University Student Health Center to administer medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed personnel.

_____ _____

SIGNATURE (OR GUARDIAN, IF A MINOR) DATE

_____ 02/2008

RELATIONSHIP TO PATIENT