Millersville University Health Services Health Form Instructions

Millersville University Health Services is dedicated to ensuring a healthy living and studying environment at Millersville University. Academic success and personal growth can only be enhanced through a healthy campus community. Health Services is committed to services that promote healthy life style choices, preventative medicine, and health education.

Health Services Information

Millersville University Health Services is centrally located in the Witmer Building. The medical staff is physician directed and includes a nurse practitioner and registered nurses who educate, evaluate and treat Millersville University students.

Office Hours
Monday through Friday 8a.m. – 5p.m.  
By Appointment Only  
Call (717) 872-3250 to schedule

Eligibility

Health Services cares for registered students of Millersville University and requires students to have the following records on file:
- Medical Practitioner’s Report of Health
- Tuberculosis Screening
- Immunization Record (Please refer to immunization information on the last page.)
- Student Report of Health History

Failure to complete these requirements will only complicate your registration now and in the future.

The Student Report of Medical History, the Tuberculosis Screening Questions, and the HIPPA Acknowledgement Statement should be completed by you, the student. The other forms are to be completed by your personal health care practitioner. Mail all completed forms directly to:

Millersville University Health Services  
Witmer Building, P.O. Box 1002  
Millersville University  
Millersville, PA  17551-0302

Please review your entire immunization status with your medical practitioner. For your own protection, be certain that you are adequately immunized.

These health history forms are part of your university record and are held in the strictest confidence by Health Services.

If a student, regardless of status, expects to utilize Health Services, he/she must have a physical form on file. This information is essential for proper medical care to be given.

Emergency Care

If a student has a medical problem that cannot wait until the following day, Lancaster General Hospital and Lancaster Regional Medical Center provide emergency services and are located within 5 miles of campus.

- On campus call 3-911
- Off campus call 911

Services

All services (medical care, health education) are provided by appointment. Students may be given an appointment with any of the practitioners at Health Services (physician, nurse practitioner or registered nurse), or referred to an appropriate healthcare facility (hospital, specialists) as indicated. Services offered include:

- Evaluation and treatment of acute illness and injury
- Cooperative care with family practitioners to manage chronic medical conditions
  - Immunotherapy/Allergy injections
  - Monitoring laboratory tests for disease or medication management
- Student teacher certification examinations
- Athletic physicals
- Pre-employment examinations
- Women’s health (Pap smears, pelvic exams, breast exams)
- Sexually Transmitted Infection testing and treatment
- In-house laboratory testing
  - Strep A
  - Mononucleosis
  - Urinalysis
  - Pregnancy
  - Tuberculosis
  - Blood sugar
- Outside laboratory testing
  - Laboratory specimens can be collected and sent to independent laboratories as ordered by a medical provider. Health Services works cooperatively with Quest, ACM, and CDD laboratories. The costs of these tests are the responsibility of the student.
- Health Promotion and Education
  - Immunizations
  - Smoking Cessation

**Fees**

There are no charges for office visits at Health Services, but there may be charges for some laboratory tests, some physical examinations, injections, routine gynecological examinations (not associated with illness) and immunizations. Students may pay at the time of service by cash, check, or the Millersville Advantage Plan (MAP) card. Billing to a student’s university account through the Bursar is another payment option. If this option is used, it is the student’s responsibility to make payment through the Bursar’s office. An example of Health Services fees include:

- Strep A test - $5
- Mononucleosis - $5
- Pregnancy Test - $5
- Well Woman Exam - $30 (Pap Smear and other laboratory costs require insurance coverage or are the responsibility of the student)
- Immunotherapy/Allergy Injections - $5

**Health Insurance Information**

Health Services does not require that students have health insurance to be seen, nor does Health Services charge an office visit fee or participate with third party billing. There are some charges for medications or minor services which can be paid for at the time of service or attached to the student’s university bill.

If a student needs medical care or laboratory services that are not available at Health Services, payment for those services will be the responsibility of the student. Please be familiar with your insurance coverage, its allowances and limitations.

Make a copy of the front and back of your insurance cards (medical and prescription) and attach to the medical forms. This will provide Health Services with important information if referrals, diagnostic tests or prescription medications are needed.

Health Services has encountered many obstacles in obtaining permission from an HMO provider to refer students for treatment or diagnostic tests that fall outside our scope of practice. (ie: x-rays, emergency laboratory work, referral to specialist) Please check with your HMO provider as to their policy regarding this matter. Some HMO providers may designate a local primary care facility or request that the student return home. If your HMO provider requires pre-approval, the student will be required to get the approval at their time and expense. Again, please be familiar with your insurance allowances and limitations.

**University Sponsored Health Insurance**

An accident and sickness insurance plan is offered to Millersville University students. It can be extended to a student’s spouse or dependents, if desired. Student insurance is available through Consolidated Health. Brochures are available at Health Services and at Consolidated Health’s website: www.chpstudnet.com.
Medications

Limited selections of prescription and over-the-counter medications are available at Health Services, many of which are free or available for a nominal fee. Medications that are prescribed by a Health Services practitioner and not in stock at Health Services can be filled and purchased at any local pharmacy. Please refer to our website for a list of local pharmacies.

Because Health Services is not a full-service, licensed pharmacy, we cannot process prescriptive insurance plans, or fill prescriptions from outside practitioners.

Equipment

Crutches, splints and some other orthopedic appliances are available for loan from Health Services. Charges will be incurred if items are damaged or not returned.

If you use hypodermic needles for medical purposes, they must be disposed of in a puncture proof container. These containers are available free of charge from Health Services.

Transportation

Millersville University Police Department Police Officers and Security Officers can assist in transporting students from on-campus locations to Health Services if needed. Off-campus transportation, for referrals made by Health Services, may be available by security officers, but is not guaranteed. These transports, when available, are Monday – Friday. Students may want to consider a backup plan in the event that transports are not available.

Confidentiality

All records are confidential and securely stored. A student’s written consent is required to release any information, except in cases of medical emergency or court order. Health Services adheres to the Health Insurance Information Portability and Accountability Act (HIPAA) guidelines and regulations to ensure privacy of student health information.

Intercollegiate Athletics

In addition to the required admission health evaluation and physical exam, a pre-participation and yearly, brief interim physical examinations are required for all intercollegiate athletes.

Immunization Information

Rubella (German measles): At least one dose of rubella vaccine given on or after the first birthday, or show laboratory evidence of immunity. MMR, MR or single antigen rubella vaccine is acceptable.

Measles (Rubeola): Two doses of measles vaccine given on or after the first birthday. The two doses must be separated by at least one month. MMR vaccine is preferred; however, MR or single antigen measles vaccine is acceptable. Laboratory evidence of immunity is acceptable.

Mumps: At least one dose of mumps vaccine given on or after the first birthday. Mumps vaccine is included in the MMR vaccine.

Tetanus-Diptheria: Completion of the primary series of DPT, DT or Td, and a booster dose within the past 10 years. Tdap is now the recommended booster vaccination.

Hepatitis B: All students entering into professions where the exposure to blood/body fluids is likely, should begin and/or have completed the Hepatitis B vaccination series prior to beginning classes.

HPV (Gardasil): For women only. This vaccine works by preventing the most common types of Human Papilloma Virus (HPV) that cause cervical cancer and genital warts. It is given as a 3-dose vaccine.

Meningitis (Menomune/Menactra): Immunization is recommended. As of 7-1-2002, residential students are required to either show proof of meningococcal immunization or sign a waiver form refusing the vaccine and acknowledging the risks of not being immunized, to gain access to their resident hall room. Waiver form questions are directed to the Millersville University Housing and Residential Life Office – (717) 872-3162
Medical Practitioner’s Report of Health

To the Examining Practitioner: Please review the student’s history, complete and sign all forms as indicated. Please comment on all positive answers to help us better care for this individual. This individual has been accepted; the information within these forms will not affect his or her status.

All blanks must be completed by answering “yes” or “no” or by supplying the information requested. Unanswered questions or incomplete answers will require that the form be returned for completion.

This report is confidential and should be mailed or faxed by the individual or practitioner directly to: Millersville University Health Services, Witmer Building, P.O. Box 1002, Millersville, PA 17551-0302. Fax: 717-871-2243.

Name: ______________________________________________________ Date of Birth: __________

Address: ___________________________________________ City: ______________ State: __________ Zip: ______

Student ID Number (if known): ____________________________ □ Male □ Female

B/P: _____/____ Pulse: ______ Height: ______ Weight: ______ Corrected Vision: Right: 20/____ Left: 20/____

Are there any abnormalities of the following systems? Describe fully if positive. Use additional sheet if necessary.

<table>
<thead>
<tr>
<th>Organ System</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Head, Ears, Nose or Throat</td>
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<td>Eyes</td>
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<td>Respiratory</td>
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<td>Cardiovascular</td>
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<td>Genitourinary – Hernia (males)</td>
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<td>Musculoskeletal</td>
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<td>Metabolic/Endocrine</td>
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<td>Neuropsychiatric</td>
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<td>Skin</td>
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</tbody>
</table>

Is there loss or seriously impaired function of any paired organ? No _____ Yes _____, please explain: ____________

Recommendations for physical activity (PE, Intramurals, ROTC): Unlimited _____ Limited _____, please explain:

Is the patient now under treatment for any medical or emotional condition? No _____ Yes _____, please explain:

Do you have any recommendations regarding the care of this individual? No _____ Yes _____, please explain:

Practitioner’s Signature: ____________________________________________
Address: __________________________________________________________
Print Last Name: __________________________ Date: __________ Phone: __________

For University Use Only

☐ The candidate is found physically fit with no restrictions
☐ The candidate is found physically fit with the following restrictions:

Signature of University Practitioner __________________________ Date __________
The Centers for Disease Control and Prevention, The American College Health Association and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at risk of tuberculosis as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

Students:

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for you. **If you check any boxes in sections 1-5, you are required to have a Tuberculosis Skin Test (PPD).** A history of BCG vaccination should not preclude testing a member of a high-risk group. Check the box at the bottom of the page if sections 1-5 do not apply to you. Sign and date the form at the bottom. If you are under eighteen years of age, your parent or guardian will need to sign the form. Remember to take this form with you to your physical exam appointment; your healthcare practitioner will need this information to complete your physical exam.

- **Section 1:** Check the box if you have any of the following Possible Symptoms of Tuberculosis.
  - Unexplained weight loss
  - Unexplained elevation of temperature for more than one week
  - Unexplained night sweats
  - Unexplained persistent cough for more than 3 weeks
  - Unexplained cough productive of bloody sputum

- **Section 2:** Check the box if you have any of the following Risk Factors for Tuberculosis Infection.
  - Close contact with a known case of infective tuberculosis
  - Use of illegal injected drugs
  - HIV (Human Immunodeficiency Virus) infection
  - Health care worker
  - Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)
  - A positive skin tuberculosis test in the past

- **Section 3:** Check this box if you have any of the following Risk Factors for Tuberculosis Disease.
  - Diabetes mellitus
  - Lymphoma, leukemia, or cancer of the head, neck or lung
  - Gastrectomy or jejuno-ileal bypass (gastric bypass surgery)
  - Greater than 10% below ideal body weight
  - Silicosis (occupational lung disease)
  - Organ transplant recipient

- **Section 4:** Check this box if you are a Nursing or Medical Technology Major.

- **Section 5:** Check this box if you were born in or in the last 5 years, you have lived or traveled for 30 days or more in any of the following Areas with a High Prevalence of Tuberculosis as defined by the World Health Organization and the PA State Health Department.
  - Africa – All countries
  - Asia/Southeast Asia, Asia/Pacific Islands – All countries
  - North, Central and South America – Argentina, Bahamas, Belize, Bolivia, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
  - Europe – Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
  - Middle East – Bahrain, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic

☐ No, none of the items listed in sections 1-5 apply to me.

____________________________________________________  __________________
Student Signature (Parent/Guardian Signature if student less than 18 years of age)                             Date
Tuberculosis Testing

The above Tuberculosis Risk Assessment must be completed by the student or parent/guardian, signed and returned with the physical form. All nursing and medical technology students are required to have an annual PPD regardless of risk assessment. Also, a history of BCG vaccination should not preclude evaluation of a member of a high risk group.

Are any of the boxes checked in Sections 1-5 of the Tuberculosis Risk Assessment?

_____No. If no, Stop; Sign below

_____Yes. If yes, tuberculosis testing is required through either a PPD skin test or chest radiography.

Tuberculin Skin Test (PPD)

Date Given: _____/_____/_____   Date Read: _____/_____/_____

Result: __________mm. (Record actual mm of induration; transverse diameter; if no induration, record “0”)

Interpretation (based on induration as well as risk factors): Positive: _____   Negative: _____

Chest Radiography

Date of chest radiography: _____/_____/_____   Result: _____Normal _____Abnormal

(please attach a copy of the radiography report)

Document any treatment the student has received for either a positive TB skin test or active tuberculosis.

Medication(s): __________________________________________________________

Date Started: _____/_____/_____  Date Completed: _____/_____/_____  

Immunization Record

1.  **Tetanus-Diphtheria or Tetanus-Diphtheria-Pertussis**
   a.  Tetanus-Diptheria booster must be within the last ten years
   b.  Completed primary series

2.  **Measles, Mumps Rubella** (two doses required)
   a.  Dose #1 (12 months)
   b.  Dose #2 (after 1980)
   c.  Has report of positive immune titer
      • Disease: ____________
      • Disease: ____________
d. Had disease – confirmed by medical records
   • Disease: ____________       ______/______  Mo          Yr
   • Disease: ____________       ______/______  Mo          Yr

3. **Hepatitis B** (Strongly recommended – mandatory for all students entering majors where exposure to blood/body fluids is likely)
   a. Dose #1: _____/_____  Dose #2: _____/_____  Dose#3: _____/_____
      Mo            Yr          Mo            Yr          Mo            Yr
   b. Hepatitis B surface antibody: _____/_____  Reactive: _____  Non-reactive: _____  Mo            Yr

4. **Polio** (strongly recommended)
   a. Completed primary series  ______/______  Mo            Yr

5. **Varicella**
   a. Had disease: Yes: _____  No: _____  Vaccinated: _____/_____  Mo            Yr

6. **Menomune or Menactra** (strongly recommended)  ______/______  Mo            Yr

7. **Gardisil**
   a. Dose #1: _____/_____  Dose#2: _____/_____  Dose#3: _____/_____
      Mo            Yr          Mo            Yr          Mo            Yr

**Medical Practitioner’s Disclosure**

☐ I certify that my patient ______________________________________ is fully immunized according to the recommendations of the Commonwealth of Pennsylvania Department of Health.

☐ I certify that my patient ______________________________________ should be exempt from the immunization requirement for the following medical/religious reasons: ____________________________________________________________

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Practitioner’s Signature: ______________________________________

**HIPPA Consent**

By signing below, I hereby acknowledge that I have downloaded a copy of Millersville University Health Services’ Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by Millersville University Health Services and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health related information for treatment purposes, payment activities and healthcare operations of Millersville University Health Services as described in the notice.

________________________________  _________________  __________________________
Student Signature     Date    Print Name
# Student Report of Medical History

**Name:** _____________________________________________  **Date of Birth:** _______________________

**Student ID Number (if known):** _______________________________________

________________________________________________________________________________________________________________________

Name, relationship, and address of person to be contacted in an emergency          Home telephone number

Emergency contact business address          Business telephone number

☐ Father  ☐ Mother  ☐ Other: _______________________

Name of insurer

Insurer’s date of birth    Insurer’s social security number

Insurance company name    Policy Number – ID Number

Insurance company address          Group Number

## Family History

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<th></th>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age of Death</th>
<th>Cause of Death</th>
<th>Have any of your relatives ever had any of the following?</th>
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<td>Father</td>
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<td>Yes</td>
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<td>Mother</td>
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<td>Brothers</td>
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<td>Sisters</td>
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<td>Yes</td>
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<th>Yes</th>
<th>No</th>
<th>Relationship</th>
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<tr>
<td>Tuberculosis</td>
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<td>Diabetes</td>
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<td>Kidney Disease</td>
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<td>Heart Disease/Sudden Cardiac Death before age 50</td>
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<td>Stomach Disease</td>
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<td>Asthma, Hay Fever</td>
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<td>Epilepsy, Convulsions</td>
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<td>Relationship</td>
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## Personal History – Please answer all questions.

Comment on all positive answers on an additional sheet of paper.

<table>
<thead>
<tr>
<th>Have You Had?</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Scarlet Fever</td>
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<td>Gum/Tooth Trouble</td>
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<td>- Appendectomy</td>
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<td>- Tonsillectomy</td>
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<td>- Hernia Repair</td>
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<td>- Other (Specify)</td>
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<td>Hay Fever</td>
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Has your physical activity been restricted during the past 5 yrs? (give reasons and durations)

Have you been rejected for or discharged from military service because of physical, emotional or other reasons?

Have you had difficulty with school, peers or teachers?

Have you received treatment or counseling for a nervous condition, personality or emotional disorder?

List, on a separate sheet, any medication you take on a daily or regular basis.

**Student Signature** ______________________  **Practitioner’s Signature (acknowledging Review)** ______________________  **Date** ______________________
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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your health care practitioner, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of this health center, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This included the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a health care practitioner to whom you have been referred to ensure that the practitioner has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a diagnostic test may require that your relevant PHI be disclosed to the health insurance plan to obtain approval for the test.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of this health center. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students or nurse practitioners, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to a medical or nurse practitioner student that is seeing patients in our health center. We may also call you by name in the waiting room when we are ready for you to be seen.

We may also use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroner request, funeral director request, criminal activity, national security, worker’s compensation. Under law we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your health care practitioner or this health center has taken action in reliance on the use or disclosure indicated in the authorization.
Your Rights

The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your health care practitioner is not required to agree to a restriction that you request. If your health care practitioner believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care practitioner.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.

You may have the right to have your health care practitioner amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our health center of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to the form, please ask to speak with our HIPPA Compliance Officer in person or by telephone at our main office number (717-872-3250).

Please sign the acknowledgement statement on the Millersville University Health Services Report of Health.