Millersville University
HEALTH SERVICES

Student's Name: _____

Date of Birth: _____

Privacy Practice Notice and Consent for Treatment

NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose: Millersville University Health Services staff follows the privacy practices described in this notice. Health Services maintains your medical information in a confidential manner, as required by law. However, Health Services may use and disclose your medical information to the extent necessary to provide you quality healthcare.

Applicable Law: The staff members at Health Services follow privacy practices that are based on the Family Educational Rights and Privacy Act (FERPA). FERPA is the law that protects the privacy of your education and treatment records at Millersville University, including records maintained by Health Services. For more information about FERPA visit: https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

Your written authorization is required for any other uses or disclosures not described below. You may revoke your permission at any time, and such revocation will be effective immediately upon submitting a written revocation. Absent written consent, your medical information will not be used for marketing purposes or sold to outside entities.

Permissible Use / Sharing of Medical Information: Your medical information may be used/shared for the following purposes, including but not limited to:

- Treatment of your condition across your care team, including, but not limited to pharmacists, counseling center, behavioral intervention team, disability services, student support, athletic trainers, etc.
- Improving the quality of care provided.
- Appointment reminders.
- Information about treatment alternatives or benefits/services related to your health.
- Treatment and operation functions through Electronic Health Record Vendors.
- To a family member, relative or elected representative, when it is vital to your continued care, in emergency situations or when you are otherwise unable to make decisions regarding your medical care.
- To school officials with a legitimate educational interest.
- University administrative advisors, including the legal office, and/or agencies or individuals that oversee our operations or help carry out our responsibilities when it is vital to your continued care, in emergency situations or when you are otherwise unable to make decisions regarding your medical care.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Specific research projects.
- To prevent a serious threat to health or safety of you or a member(s) of the University community.
- For law enforcement purposes, including but not limited to, in response to a court order or other legal process, to identify or locate an individual being sought by authorities, about a crime victim under restricted circumstances, about a death that may be the result of criminal conduct, circumstances relating to reporting information about a crime, etc.
- To a disaster relief agency, if you are injured in a disaster.
- To public health authorities for reports of child abuse or neglect or if we believe you have been a victim of abuse, neglect, or violence.
- Lawsuits and disputes. However, the University will attempt to provide advance notice of a subpoena before disclosing the information.
- As required by federal, state, or local law or government policy.

Alcohol and Drug Use Information: Such information will only be disclosed, as follows:

- Your written consent to share mental health or medical information related to substance abuse assessment/treatment;
- A court order signed by a judge that requires disclosure of the information;
- Medical personnel need the information to meet a medical emergency;
- If necessary to report a crime, a threat to commit a crime, or to report abuse or neglect as required by law.

Medical Information Rights: You have the following rights regarding your medical information, provided that you make a written request to invoke the right.

- Right to request restrictions. You may request limitations on your medical information we use/disclose for healthcare treatment or operations, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency services.
- Right to confidential communications. You may request communication in a specific manner or location, but you must specify in writing how or where you wish to be contacted.
- Right to request an amendment. If you believe your medical information is incorrect or incomplete, you may request an amendment. However, we are not required to accept the amendment.
- Right of breach notification. You may be notified if there is a breach of your medical information.
- Right to inspect and request a copy or records. You may inspect and request a copy of your medical information. There may be a fee for this service. In limited circumstances, your request may be denied.

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- Right to accounting disclosures. You may request a list of disclosures of your medical information made to persons or entities, other than for healthcare treatment or operations, in the past six calendar years. After the first request there may be a charge.
- Right to a copy of this Notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.
- Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint. You will not be penalized or retaliated against for making a complaint.
- The University and you will be governed by this Notice for as long as it is in effect. Health Services may change this Notice, which will be effective for medical information we have about you, as well as any information we receive in the future. Each time you register for healthcare services, you may receive a copy of the Notice in effect at the time.

Contact Information: Contact the Health Center Director in writing if:

- You wish to file a complaint;
- You have any questions about this Form;
- You wish to request restrictions on uses/disclosures for health care treatment, payment, or operations; or
- You wish to exercise your rights outlined above.

For more information, please visit the Health Services website: https://www.millersville.edu/healthservices

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MILLERSVILLE UNIVERSITY HEALTH SERVICES- CONSENT FOR TREATMENT

- I hereby consent to receive medical care from Health Services at Millersville University. By submitting this form, I certify that I have read, understood and agree to be bound by the following:
- I consent to the use or disclosure of my health information by the Health Services staff for the purposes of diagnosis or treatment in order to conduct health care operations.
- I understand that this is a general consent for treatment and additional consent maybe required for specific procedures.
- I understand that I have the right to request a restriction or limitation on how and to whom my health information is used or disclosed for the above purposes. Health Services is not required to agree to such a request, but if agreed upon, the service will comply unless the information is needed to provide me with emergency treatment.
- I understand that this consent for treatment remains in effect unless withdrawn by me in writing and that I may withdraw this consent at any time.
- I understand that I have a right to ask questions regarding treatment and may refuse such treatment until these questions are answered to my understanding.
- I understand that I have a responsibility to actively participate in my treatment and care, including providing honest and complete answers to questions relevant to my care.
- Any type of audio or video recording device is strictly prohibited at any location within Health Services to ensure patient confidentiality and privacy. Any type of audio or video recording of telehealth sessions is prohibited.

☐ **I acknowledge receipt of Health Services' Notice of Privacy Practices document.**

☐ **I consent to be evaluated and treated by Health Services providers.**

Student's Signature: _____ **Date:** _____