Emory University Student Health Services
1525 Clifton Road, Atlanta, Georgia 30322
Phone 404.727.7551, Fax 404.727.5349

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 2003, federal guidelines contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that patients (or parent or guardian if the patient is a minor) give specific instructions to healthcare providers and healthcare organizations regarding the use and disclosure of their individually identifiable health information, also known as Protected Health Information. Generally, Emory University Student Health Services (EUSHS) utilizes Protected Health Information for purposes of treatment (including interactions between EUSHS clinical providers and nurses and interactions with Emory specialty physicians and other outside healthcare providers), payment (including interactions with your insurance company) and EUSHS and Emory University operations (including ensuring your compliance with Emory immunization requirements, quality assurance and evaluations of our EUSHS business and clinical practices). At the time you complete this form, you will also be given a "Notice of Privacy Practices" that delineates more fully how health information about you (as a patient at EUSHS) may be used and disclosed and how you can get access to your individually identifiable health information. In order that we may have permission to utilize your Protected Health Information, including the information in your Entrance Medical Record and Immunization Form, we ask that you (or your parent or guardian if you are under 18 years of age) please complete this 2-page authorization form prior to you arrival at Emory. You should keep the two yellow copies (which includes your signature on Page 2) of this Authorization for your personal records.

I hereby authorize the use or disclosure of any of my health information, including health information that identifies or could be used to identify me (or the Patient identified below, if I am signing this Authorization as the parent or personal representative of a patient) as described below. *(Throughout this form, all health information that is subject to this Authorization is referred to as "Protected Health Information.")*:

Patient's Name: _____ **Emory Student ID # *(if known)*:** _____

Protected Health Information that May be Used/Disclosed: The Protected Health Information that may be used or disclosed consists of the following information (please choose one option):

_____ All Protected Health Information contained in my medical record, including my Entrance Medical Record and Immunization Form, ***or***

_____ Information limited to the following (specify type of Protected Health Information that may be disclosed, such as laboratory results, radiology reports, physicians' notes, immunization records, etc.): _____
_____

Persons/Entities Authorized to Use/Disclose the Protected Health Information: The person(s) or class of persons who is/are authorized to make the use/disclosure of this Protected Health Information is/are (you may choose more than one option):

_____ Emory University Student Health Services (EUSHS)

_____ Other (describe): _____

Purpose(s) for Which the Protected Health Information May be Used or Disclosed: The Protected Health Information may be used or disclosed for the following purpose or purposes (you may list more than one):

_____ To provide EUSHS with Protected Health Information for purposes of: providing health care to me (or the Patient listed above; receiving payment for services rendered; performing healthcare operations while I am (the Patient is) a student at Emory University; and/or ensuring compliance with Emory University immunization requirements.

_____ As requested by me (for the following purpose: _____)
Optional

_____ Other (describe): _____
_____
_____

EUSHS Authorization for Use/Disclosure of Protected Health Information (Page 2)

Patient's Name: _____ **Emory Student ID # *(if known)*:** _____

Persons/Entities by Whom the Protected Health Information May be Used/to Whom it May be Disclosed: The Protected Health Information may be used by or disclosed to the following persons, departments, agencies, and/or companies (you may choose one or both options):

_____ EUSHS, Emory University Hospitals and The Emory Clinic (for purposes of treatment, payment and healthcare operations); Emory University (for purposes of monitoring immunization status and compliance); health insurers, other healthcare providers and other third parties (for purposes of treatment and/or billing and collections)

_____ Other persons/entities limited to the following (describe): _____
_____
_____

Expiration Date/Event: This Authorization will expire on the date or upon the occurrence of the event set forth below (please choose only one option):

_____ When I revoke this Authorization in writing as described below.

_____ On the following Expiration Date: _____

_____ Upon the occurrence of the following event (for example, two years after I am no longer enrolled as a student at Emory University, etc.): _____

Re-Disclosure of Protected Health Information and Revocation of Authorization: I understand that any Protected Health Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may not be protected by federal privacy regulations. I understand that I may revoke this Authorization in writing at any time by sending a letter stating that I revoke this Authorization to: ***Emory University Student Health Services, 1525 Clifton Road, Atlanta, GA 30322***. After I revoke this Authorization, my (the patient's) Protected Health Information will not be used or disclosed except to the extent that use or disclosure was already made in reliance on this Authorization or to the extent that use or disclosure is required and permitted by law.

Provision of Health Care Not Conditioned on Authorization: I understand that my receipt of health care (or the Patient's receipt of health care) is not conditioned on my signing of this Authorization, unless the health care that I am (the Patient is) to receive is solely for the purpose of creating Protected Health Information for disclosure to a third party (for example, performance of a physical examination, the results of which the patient wishes to have disclosed to a life insurance company for underwriting purposes).

Parent or Personal Representative Signing on Behalf of Patient (*initial below if applicable)*:

_____ I am a parent signing this form on behalf of my minor child who is the Patient referenced in this form. I certify that I have all legal right and authority to sign this form and make this authorization on behalf of my minor child.

_____ I am the personal representative of the person who is the Patient referenced in this form. I am over 18 years of age and I have all legal right and authority to sign this form and make this authorization on behalf of the Patient. My authority to act for the Patient comes from (please describe, such as power of attorney for health care, court order, etc.): _____
_____

After I sign this form, I will keep or receive a copy of it and a copy also will be placed in my (the Patient's) medical record.

_____ _____
Signature of Patient ***Date***

OR

_____ _____
Signature of Parent or Personal Representative ***Date***

_____
Name of Parent or Personal Representative