BIOLA UNIVERSITY

Student Health Center
13800 Biola Avenue
La Mirada, CA 90639

P: (562) 903-4841
F: (562) 906-4512

Notice of Privacy Practices

STUDENT NAME: _____ **STUDENT ID #:** _____ **DATE OF BIRTH:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION. PLEASE REVIEW IT CAREFULLY.

Biola University Student Health Center (SHC) values the privacy of its patients and the confidentiality of the personal and health information entrusted to us. In order to protect this privacy, we have policies and procedures to limit disclosures of Personal Health Information (PHI) to those individuals necessary for the medical care of our patients, those for which the patient has given permission and/or those required by law or public safety, and in certain emergency situations. Although we are not a "covered entity" subject to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we comply with the laws of the State of California pertaining to privacy of medical records. In cases where this Notice conflicts with any provision of local, state or federal law, the provisions of such law(s) shall prevail.

The SHC originates, records, and maintains health information describing patients' health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. This health information may be used or disclosed by the SHC for treatment, payment, and healthcare operations. The SHC, when necessary, may use or release your health information in the following ways:

- As a basis for planning your care and treatment;
- As a means of communication between other healthcare professionals who may assist in your medical care;
- As a source of information to create a bill for healthcare services rendered;
- As a means by which a third-party payer can verify that services billed were actually rendered;
- As a tool for routine healthcare operations, such as assessing quality of healthcare operations and utilization review;
- Under very restricted circumstances, as a source of information for public health officials charged with protecting the health of the public;
- To protect you from a threat to your health or safety or to protect the health or safety of another person;
- To comply with a judicial order, lawfully issued subpoena, or lawfully issued search warrant;
- To report suspected child abuse or neglect or elder abuse or to identify suspected victims of abuse, neglect, or domestic violence to the appropriate authority, as required by law;
- In other circumstances where federal or state law requires that we disclose your PHI to others.

The SHC has a text messaging program in which subscribers receive brief, timely information about upcoming appointments, the availability of lab results, and notification to contact the SHC and/or check secure patient messages. By signing this Notice: (a) you agree to receive such texts from the SHC, (b) you acknowledge that message and data rates may apply, and (c) you further acknowledge that you may opt-out of the program at any time through "Edit Profile" in the Patient Portal.

Disclosure

We will not disclose your PHI without your signed authorization, except as described in this Notice. We will disclose your PHI to you and to those who you have specified in this Notice (or otherwise in writing) to receive it. We will discontinue disclosure of your PHI to those who you have authorized to receive it after we have received your written revocation of the authorization. Disclosure of PHI may be made by electronic means (i.e., email) unless you have requested in writing not to authorize disclosure by such means.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORAMTION. PLEASE REVIEW IT CAREFULLY.

You have the right to:

- Request restrictions as to how your healthcare information may be used or disclosed in order to complete treatment, payment or healthcare operations. Circumstances may not permit us to comply with such requests.
- Revoke in writing your authorization to the person(s) authorized to receive disclosure except to the extent that we have already taken action in reliance upon the authorization.
- View or request copies of your medical information. A fee may be charged for copying medical records.
- Receive confidential communications concerning your medical condition and treatment.
- Request disclosure of your PHI by alternative means.
- Request an amendment or submit corrections to your medical information.
- Receive an accounting of how and to whom your medical information has been disclosed.
- Receive a printed copy of this Notice.
- File a complaint if you feel your rights to privacy have been violated. Such complaints are to be directed in writing to the Director of the SHC. Anyone filing a complaint will not be subject to any form of retaliation.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will post these changes on the University website. All health records are destroyed 7 years after the student has left the University.

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I request the following restrictions to the use or disclosure of my health information from the list above:

_____

_____

I give access to my medical records to the person(s) listed below and for the time period stated below.

Name _____ Effective dates ____/_____/_____ until ____/_____/_____

Name _____ Effective dates ____/_____/_____ until ____/_____/_____

Name _____ Effective dates ____/_____/_____ until ____/_____/_____

Name _____ Effective dates ____/_____/_____ until ____/_____/_____

BY SIGNING THIS FORM, I CONSENT TO THE BIOLA UNIVERSITY STUDENT HEALTH CENTER'S USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS LISTED ABOVE. EXCEPT AS PROVIDED IN THIS NOTICE, ANY OTHER USE OF MY PERSONAL HEALTH INFORMATION MUST HAVE MY WRITTEN CONSENT BEFORE DISCLOSURE TO ANY PERSON.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature if under 18: _____ Date:_____