



# Student Health Center (SHC)

## Summary of Notice of Privacy Practices

Initial Effective Date, April 14<sup>th</sup>, 2003

This is a summary of the SHC Notice of Privacy Practices. We are required by law to maintain the privacy of your health information and to follow the privacy practices in this notice. Please review it carefully. For a complete, detailed account of the university's Notice of Privacy Practices, please refer to "Pepperdine University's Notice of Privacy Practices," available upon request or on Pepperdine University's internet website: <http://www.pepperdine.edu/provost/content/hipaapractices.pdf>

### What is "HIPAA?"

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your Protected Health Information (PHI), with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific PHI outside of our system except when the release is required or authorized by law or regulation.

### What is "PHI?"

Protected Health Information (PHI) is all the information regarding your health care at the SHC, health care information given to the SHC at your request by other providers, and health care billing information. Generally, it is the information in your medical record. The SHC is required by law to maintain the privacy of all PHI, to provide you with notice of our legal duties and practices, to abide by the terms of this Privacy Notice, and will provide clients with a copy of the revised notice.

- A. Uses and Disclosures of PHI: We use and disclose health information about you for treatment, payment, and healthcare operations. For example, a provider may need to discuss PHI to an insurance company to obtain authorization to order an x-ray. A provider may need to discuss PHI with the pharmacist to order a medication over the phone. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- B. Under limited circumstances, the SHC may use or disclose your PHI **without** your consent. These include:
  - 1. Diseases that must, according to state law, be reported to the Public Health Department (examples include tuberculosis, some sexually transmitted diseases, and anthrax.)
  - 2. Emergency situations in which you are unable to give consent and your health care provider attempts to get consent as soon as it is reasonably practicable after delivery of care.
  - 3. Your health care provider cannot get consent due to substantial barriers in communication, and the health care provider determines that your consent is inferred from the circumstances.
  - 4. If the SHC is required by law to treat you, and your health care provider has tried but is unable to get your consent.
  - 5. Review by the SHC for internal quality assessment, or by an accrediting body, such as the Association for Accreditation of Ambulatory Health Care.
  - 6. We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or a possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.
- C. If other applicable law prohibits or limits use or disclosure of your PHI, the SHC follows the more stringent law (i.e. subpoena).
- D. Any use or disclosure other than those described above is done only after you give your consent. You may cancel your consent at any time by notifying the SHC in writing.
- E. PHI disclosed at your request by the SHC to another health care provider can be disclosed by them without the knowledge of the SHC.

You have the right:

- To request restrictions on certain uses and disclosures of your PHI.
- To receive confidential communications of your PHI.
- To inspect and be provided a copy of your PHI, unless this might be harmful to you or to others.
- To request an amendment of your PHI.
- To receive an accounting of disclosures of PHI.
- To obtain a paper copy of this Privacy Notice.
- To complain to the University or the US Health and Human Services Secretary, if you believe your privacy rights have been violated.

If you wish to file a complaint, contact the University's Privacy Official, Kim Miller, at 24255 Pacific Coast Hwy, Malibu, CA 90263 or [Kim.miller@pepperdine.edu](mailto:Kim.miller@pepperdine.edu). There will be no retaliation of any kind against you for filing such a complaint.

I have received and read the Notice of Privacy Practices form that was provided by Pepperdine University's Student Health Center.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## Medical Consent for Treatment

Name \_\_\_\_\_

ID# \_\_\_\_\_

Date of Birth \_\_\_\_\_

1. Medical Consent: I am voluntarily seeking health care and hereby consent to medical treatment, procedures, x-ray, laboratory tests, referral to a specialist, and other health care services. I have the right to refuse specific treatments or procedures or may stop treatment at any time. I am at least 18 years of age or an emancipated minor.
  - a. If I am under 18 years of age, I give permission to contact my legal guardian to obtain permission for treatment.
2. I understand that in certain instances a referral to a specialist may be warranted if the provider deems necessary. Such instances include chronic diseases or illnesses that are outside the Student Health Center's (SHC) scope of practice.
3. I understand that all information shared with the clinicians at the Student Health Center (SHC) is confidential and no information will be released without my consent. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. (Please see "Summary of Notice of Privacy Practices").
4. I understand that I can request a translator.
5. I understand that medications may have unwanted side effects and I will read the provided medication handout before starting the medication. If an allergic reaction occurs, I will seek medical care immediately, and will advise the SHC.
6. No-Show Policy: A \$25 no-show charge will be assessed to the student's account for the following reasons:
  - a. The student does not show for a scheduled ½ hour or longer appointment.
  - b. The student does not give verbal notice of cancellation between the hours of 8 a.m. to 5 p.m. the day prior for a ½ hour or longer appointment.
  - c. The student fails to reschedule a ½ hour or longer appointment between the hours of 8 a.m. to 5 p.m. the day prior to the appointment.
  - d. The student is more than 15 minutes late to a scheduled ½ hour or longer appointment.
7. If I have any questions regarding this consent form or about the services offered at the SHC, I may discuss them with the SHC staff. I have read and understand the above.
8. I understand that if I fail to follow the practitioner's instructions or medical advice, I may be released from further care through the SHC and referred to an outside practitioner.

By signing this consent form, I acknowledge that it is valid for the duration of my enrollment as a registered Pepperdine University student.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_