(Optional) Authorization to Use or Disclose Protected Health Information to Parents, Guardians, or Personal Representatives

Student's last name (please print) First name Middle name

Date of birth (Month/Day/Year) Cedarville University student ID number

As a courtesy to you, University Medical Services (UMS) has provided this authorization form so in the event that you become ill or need assistance with your health care decisions your permission may be given ahead of time to discuss your health care with persons you designate, such as parents, guardians, or personal representatives.

As required by the HIPAA privacy rule, UMS may not use or disclose your protected health information except as provided in the UMS Notice of Privacy Practices (Page 4) without your authorization. UMS can only release your protected health information to the person(s) you designate.

Effective dates for this authorization are from now until I withdraw or graduate from Cedarville University, whichever occurs first. I understand that the information disclosed above may be re-disclosed to additional parties and are no longer protected for reasons beyond the control of UMS.

I understand I have the right to

- Revoke this authorization by sending written notice to UMS and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
- Know of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
- Inspect a copy of patient health information being used or disclosed under federal law.
- Refuse to sign this authorization.
- Receive a copy of this authorization.
- Restrict what is disclosed with this authorization.

I hereby authorize UMS and any of its employees to use or disclose my patient health information to the following person(s):_____

_____(parents, guardians, or personal representatives).

Patient health information authorized to be disclosed — (Please initial applicable statement.)

_____ Standard: Any and all health information

_____ Exception: _____

For the specific purpose of (describe in detail) — (Please initial applicable statement.)

_____ Standard: Involvement in my health care

_____ Exception: _____

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature of student or student's authorized representative Date

Signature of parent or guardian **IF STUDENT IS UNDER AGE 18** Date

For UMS Staff Only

Authorized signature of UMS staff member Date