# UNIVERSITY OF PENNSYLVANIA
# STUDENT HEALTH SERVICE

**Student Health Service**
**University of Pennsylvania** **Telephone: 215-746 3535**
**3535 Market St. Suite 100** **Fax: 215-746 0800**
**Philadelphia, PA 19104-3376**

## RELEASE OF RECORDS
## CONSENT AND ACKNOWLEGEMENT FORM

**PERMISSION FOR MEDICAL TREATMENT:**

I hereby authorize the Student Health Service of the University of Pennsylvania to administer care and treatment. Such care may include evaluation of treatment of injuries and illnesses and the administration of medication orally or by injection. I also give permission to the University of Pennsylvania and to the Student Health Service of the University of Pennsylvania to secure proper treatment for me, in case of medical or surgical emergency, if according to their best professional judgment, further delay might jeopardize my welfare.

**PERMISSION FOR RELEASE OF INFORMATION:**

I hereby authorize the Student Health Service to use and disclose my personal health information as allowed by law, including but not limited to for the following purposes:

- Providing health care to me. For example, we may share your health information with individuals or offices on or off campus who provide, or assist in coordination or management of, health care.
- Processing payment. For example, we may share your health information with insurance carriers for reimbursement purposes.
- So that we may run our operations. For example, we may use your health information to perform quality assessments and or conduct training.

Once my information is disclosed, it may no longer be protected by federal and/or state laws.

Special Protections for Certain Information

Information about HIV status, mental health, and/or substance abuse is subject to special privacy under state and/or federal law. Generally, the Student Health Service will not disclose such information unless you sign a specific authorization to do so, the disclosure is allowed by court order, or in limited and regulated other circumstances.

**INSURANCE NOTICE:**

I understand that I am required to maintain health insurance. I understand that I am responsible for payment of any outstanding or unpaid medical charges.

**NOTICE OF PRIVACY PRACTICES:**

I hereby acknowledge that I have received the enclosed Notice of Privacy Practices statement.

**Student Name (please print) Last Name ____________________________First Name________________________________**

**Date of birth______________** **Student ID _________________**

**Signature ____________________________________________ Date ______________**