Student Health Service

Notice of Uses and Disclosure of Information

I understand that the University at Stony Brook Student Health Service its physicians, practitioners, and nurses are required to fully document my medical history, current condition, treatment plan and all treatment rendered, including the results of all tests, procedures and therapies. This information is required to be maintained by the organization in a safe and secure way to insure privacy and confidentiality. I understand that the information documented must be available to those involved in my care. Access to my medical record information within the organization is restricted and only available on a Need-to-Know basis.

I understand that my health care information, whether stored on paper, computer, film, or other medium is available to the University at Stony Brook Student Health Service physicians, practitioners, and nurses now and in the future on a Need-to-Know basis to health workers involved in my care, teaching, Institutional Review Board approved research, and/or internal utilization management and quality review.

I hereby authorize the University of Stony Brook Student Health Service and its physicians or practitioners to release my health information requested by any health insurance company/organization related to the claims filed for this visit/admission, or benefit assessment. I also authorize the release of medical information to other hospitals, facilities, physician(s), including my primary care physician(s) or referring physician(s), or agencies in order to facilitate my current care, to arrange transfers or the provision of other continuing care following my discharge or treatment from the University at Stony Brook Student Health Service, or in the case of medical emergency. All other access is prohibited without my specific written authorization.

Because of federal laws and/or statutes, certain types of confidential information are not covered by this authorization and, if they exist will not be disclosed or discussed to anyone outside the University at Stony Brook Student Health Service without my specific approval; these include confidential details of psychotherapy and social work counseling, substance abuse rehabilitation treatment, HIV-testing and results, and treatment of sexually-transmitted diseases.

My signature below constitutes my acknowledgment that I have read and understand the information provided in this form, that any questions I asked have been satisfactorily answered, and that I agree to this release of medical information as described herein.

Patient's Signature: ______________________________ Date: _______________________

ID# ______________________________

When patient is under legal age or incompetent to give consent, signature of legal guardian or health care agent:

Signature: ____ Date: _______________________

Relationship to Patient: _____________________________