Office of Health Services

UNITED STATES MERCHANT MARINE ACADEMY
PATTEN HALL ★ KINGS POINT, NY ★ 11024-1699
Phone: 516-726-5680 ★ Fax: 516-773-5436 ★ Email: medical@usmma.edu

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Home Address: _____

Home Telephone: _____ Cell Phone: _____

E-mail: _____

Social Security Number: _____ Date of Birth: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you are consenting to allow Office of Health Services to use and disclose your protected health information in order to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of the Department's notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Office of Health Services reserves the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Mrs. B. Susan Crowe (Office of Health Services Privacy Officer)

Telephone: (516) 726-5680

Fax: (516) 773-5436

E-mail: Medical@usmma.edu

Address: Office of Health Services, Patten Hall, 300 Steamboat Road, Kings Point, New York 11024-1699

SIGNATURE SECTION

I, _____ (SSN) _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to Office of Health Services to use and disclose my protected health information to carry out treatment, payment activities and heath care operations.

Signature of Plebe Candidate Date	Signature of Parent/Legal Guardian for Minors Date
Print Name	Print Name Relationship to Plebe Candidate

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed consent in the patient's chart.

Right to Revoke: You have the right to revoke this consent at any time. You may obtain a "Revocation of Consent" form at OHS and submit your written notice of your revocation to the OHS Privacy Officer listed above. Please understand that revocation of this consent will *not* affect any action taken in reliance on this consent before we received your revocation, and that OHS may decline to treat you or to continue treating you if you revoke this consent.