



March 2019

Congratulations and welcome to The Claremont Colleges (TCC) and your Student Health Services!

Attached is your **Entrance Personal Health History/Medical Examination Report Form**.

This form provides your history of previous medical care from your private health care provider and is the basis for your continuing medical care in college. Completion in full regardless of your status (i.e. part-time, exchange, or transfer student) is required for registration at any of The Claremont Colleges.

Please complete pages one, two and three yourself. Pages four and five are to be completed by your private health care provider. Please note that **required** immunizations and screening include:

- Hepatitis B (HBV) - 3 dose series
- Measles, Mumps, and Rubella (MMR) - two dose series
- Meningococcal Conjugate (MCV4) and booster dose at or after age 16
- Primary series of Tetanus, Diphtheria, Pertussis and Tdap booster within the last 10 years
- Tuberculosis screening questionnaire (TB skin test, CXR, or Quantiferon blood test to be performed, if indicated)
- Varicella Zoster (VZV) - 2 dose series or date of disease

Immunization records are required to prevent outbreaks of disease on campus as well as to help recognize students who are at risk should a disease outbreak occur. If you cannot locate your immunization records, you have two options:

- You can be re-immunized.
- You can have a blood test to determine immunity. If the blood test indicates that you are not immune to HBV, MMR, or VZV you will have to be re-immunized.

Once your form has been completed, e-mail it directly to Student Health Services (shsrecords@claremont.edu).

All students are required to carry major medical insurance to provide supplemental coverage in the event of an acute injury or illness requiring hospitalization. A Student Health Insurance Plan (SHIP) is available to students attending TCC. Proof of insurance is required at all undergrad colleges and for all grad and undergrad International Students. The Claremont Colleges Insurance plan is required for all International Students. Please contact your Dean of Students' Office for brochures and plan information.

The staff at Student Health Services looks forward to assisting you with your health care needs while you are at The Claremont Colleges. Our website, www.services.claremont.edu/shs/ has more information about our services.

Thank you for your cooperation. Your compliance helps protect the health of the entire campus community.



STUDENT HEALTH SERVICES

This information is to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the current recommendations from the Centers for Disease Control and Prevention (CDC) along with the recommendations of the Advisory Committee on Immunization Practices (ACIP).

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death. The disease strikes about 4000 Americans each year and claims about 500 lives. Between 100 and 125 meningitis cases occur on college campuses nationwide and as many as 15 students will die from the disease.

The Claremont Colleges, in an effort to keep the campus safe and as healthy as possible, now require all incoming freshmen to show proof of meningococcal vaccination. The vaccine is available at Student Health Services any day by appointment. For more information, please feel free to contact our health service and/or consult your health care provider. You can also find information about this disease on our web site, www.services.claremont.edu/shs/, which links to the website for the Centers for Disease Control and Prevention (CDC), <http://www.cdc.gov/> and the American College Health Association website, <http://www.acha.org/meningitis>.

Please note that the required Meningococcal Tetravalent (Men ACWY) vaccination is different from the recommended Meningococcal B vaccination. All students need to have had a Meningococcal Tetravalent vaccination, with a booster dose given at age 16 or older. Meningococcal B vaccinations are strongly recommended for all students, but are not required at this time.

Serving: Pomona College 1887 • Claremont Graduate University 1925 • Scripps College 1926 • Claremont McKenna College 1946 • Harvey Mudd College 1955 • Pitzer College 1963 • Keck Graduate Institute 1997

757 College Way, Claremont, CA, 91711
(909) 621-8222 • (909) 621-8472F



- Claremont McKenna College
- Harvey Mudd College
- Pitzer College
- Pomona College
- Scripps College

In order to provide a safe and healthy environment at The Claremont Colleges, **all** students are required to complete this health record **prior** to entry.

IMPORTANT GENERAL INFORMATION

- Please read prior to completing this form:
 - SHS letter of introduction
 - Information on meningococcal disease
- If documentation of immunization is unavailable, you must be re-immunized for Hepatitis B, Measles, Mumps, Rubella, and Varicella Zoster or show proof of immunity. Meningococcal vaccination at or after age 16 and a Tdap booster within the last 10 years are required.
- All forms may be submitted by e-mail to shsrecords@claremont.edu.
- **Please make a copy of this form for your records.**

This form must be returned by August 1st for the fall semester and January 15th for the spring semester.

Part I: TO BE COMPLETED BY STUDENT

Use Ink & Print Clearly

Full Legal Name _____
Last First Middle

Preferred Name: _____ Date of Birth _____ Gender: _____

ID# _____ Home Address _____
Street

City State Zip Code Country

Primary Phone () _____ E-mail Address _____

Emergency Contact:

Name _____ Relationship _____ Phone Number (Primary) () _____

Address _____ Phone Number (Work) () _____

MEDICAL CARE AUTHORIZATION

I, the undersigned, hereby specifically authorize The Claremont Colleges Services Student Health Services health care provider or whomever he or she may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor student, (under the age of 18), this treatment may proceed without prior notification of the undersigned parent or guardian. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

SIGNATURE OF STUDENT: All students must sign. If under 18 years of age, Parental Signature is also required.

STUDENT _____ DATE _____

PARENT _____ DATE _____

NOTE: A release of information must be signed and dated and on file for students 18 and older before any patient records and/or, billing information may be released/discussed with a student, parent, guardian, spouse, or healthcare provider. A form is available at <https://services.claremont.edu/shs/docs/release-of-records-to-provider/> or at Student Health Services.

Patient Name _____

PART II: PERSONAL HEALTH HISTORY: TO BE COMPLETED BY STUDENT

Have you ever been diagnosed with any of the following?

YES

- Acne, severe
- Alcohol/Drug addiction
- Allergies of any kind
- Anemia
- Anxiety or panic attacks
- Arthritis
- Asthma, including exercise induced
- Attention deficit disorder/ADHD
- Back pain, chronic
- Bipolar disorder
- Blood clotting disorder
- Cancer
- Chickenpox
- Crohn's Disease/Ulcerative colitis
- Depression
- Diabetes
- Ear, nose, or throat disorders
- Eating disorder
- Epilepsy/Seizures
- Fainting/Blackouts
- Genital herpes

YES

- Genital warts (HPV)
- Headaches, frequent, severe
- Head injury
- Hearing difficulty
- Heart disease
- Heart murmur/Arrhythmia
- Hepatitis
- High blood pressure
- Immune system problem
- Kidney disease
- Leukemia
- Loss of a paired organ (eye, kidney, testicle)
- Meningitis/Encephalitis
- Menstrual problems
- Mononucleosis
- Ovarian cyst
- Pneumonia
- Positive tuberculin skin test
- Psychiatric treatment
- Sickle cell trait/disease

YES

- Self Injury
- Thyroid condition
- Urinary tract infection (recurrent)
- Other _____

Do you have a family history of any of the following conditions? (parents, grandparents, or siblings)

- Blood clotting disorder
- Cancer
- Diabetes
- Heart disease
- High blood pressure
- Kidney disease
- Mental illness
- Migraine
- Rheumatoid arthritis
- Sudden death
- Thyroid disease
- Other _____

If you answered "YES" to any of the conditions listed above, please explain in the space below. Give the date and outcome of all conditions above or any other conditions or medical history not listed. You may attach additional sheets and old medical records if necessary.

List all other surgical procedures, except fractures, with dates _____

List all medical/psychiatric hospitalizations, with dates _____

List all significant injuries and illnesses, with dates _____

List any medications taken regularly _____

List Allergy/Medication Reaction History _____



Patient Name _____

PART III: MEDICAL INSURANCE

It is required that all students be covered by medical insurance to provide supplemental coverage for medical costs in the event of a severe illness, injury, or accident. **The Claremont Colleges Services Student Health Services does not do any medical insurance billing.** However, information about a student's medical coverage can expedite the process of community subspecialty referrals if necessary as well as an insurance identification card carried by the student.

Students of The Claremont Colleges are automatically enrolled into SHIP (Student Health Insurance Plan). Students wishing to waive SHIP coverage must submit proof of coverage prior to registration via the online waiver portal. Please note that this form is only for Student Health Service's use and does NOT waive you from SHIP. If you are not waiving SHIP coverage, please check the box below. Policy information will become available after the start of Spring semester.

Please provide current medical insurance information below:

I am enrolling into SHIP.

Name of Insurance Carrier _____

Policy Number(s) _____ Phone Number for Reporting Claims _____

Patient Name _____

Part IV: PHYSICAL EXAMINATION: TO BE COMPLETED BY A HEALTH CARE PROVIDER ONLY

Form completed by family member/relative will not be accepted.

TO THE HEALTH CARE PROVIDER: Please review the health history provided by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student's physical status, both for the student and as a basis for his/her continuing medical care.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: (Uncorrected) R 20/ _____ L 20/ _____ (Corrected) R 20/ _____ L 20/ _____

List any allergies to medications or foods _____

PHYSICAL EXAM	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
Head/EENT			
Neck/Lymph/Thyroid			
Cardiovascular			
Respiratory			
Breast exam			
Abdomen			
Hernia/Testicles			
Musculo-skeletal			
Neurologic			
Skin			

A. TUBERCULOSIS SCREENING (Required)

- Does the student have a history of a positive tuberculin skin test (PPD) in the past? Yes No
If no, proceed to #2.
If yes, include date of positive PPD, mm induration, date and results of most recent chest x-ray and documentation of any treatment received for latent tuberculosis. **Skin test should not be repeated.** Proceed to #2.
- Does the student have signs or symptoms of active tuberculosis disease? Yes No
If no, proceed to #3.
If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
- Is the student a member of a high-risk group? Yes No

Categories of high-risk students include those students who were born in or resided in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore students should undergo TB screening if they were born in or resided in countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone \geq 1 month) or other immunosuppressive disorders.

If you have answered no to questions 1-3, please stop.

If yes, place tuberculin skin test [Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm]. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

Tuberculin Skin Test: (Must be performed within 6 months of arrival on campus)

Date Placed: _____ Date Read: _____

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0".

Interpretation (Based on mm induration as well as risk factors.): Positive Negative

Or Interferon Gamma Release Assay (IGRA): Date Obtained: _____ (Specify Method) QFT-G QFT-GIT Other _____

Result: Positive Negative Intermediate

4. Chest x-ray result (Required only if tuberculin skin test in #3 or IGRA is positive): Date of CXR: _____ Normal Abnormal

Patient Name _____

PART V: IMMUNIZATION RECORD: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

B. IMMUNIZATIONS (Please fill out below) **OR Attach a copy of the Immunization Record**

Hepatitis B #1 _____ #2 _____ #3 _____ **(REQUIRED)**

Tetanus, Diphtheria, Pertussis (DPT, Dtap, DT, Td, Tdap) **(REQUIRED)**

#1 _____ #2 _____ #3 _____ #4 _____ Tdap booster within last 10 years _____

Measles, Mumps, Rubella (MMR) (REQUIRED)

MMR #1 _____ MMR #2 _____ or had disease verified by a health care provider Y N

Immunity verified by immune titer (please include lab report)

Meningococcal Tetravalent (REQUIRED) Tetravalent conjugate (preferred) Date _____

Tetravalent polysaccharide Booster _____

Varicella #1 _____ #2 _____ or Disease (date) _____ **(REQUIRED)**

Recommended Immunizations

Meningococcal B Bexsero #1 _____ #2 _____ or Trumenba #1 _____ #2 _____ #3 _____

Polio #1 _____ #2 _____ #3 _____ #4 _____ Last booster _____

Hepatitis A #1 _____ #2 _____

Human Papillomavirus (2, 4, or 9 valent) #1 _____ #2 _____ #3 _____

Pneumococcal Polysaccharide vaccine Date _____

Prior Travel Immunizations

Typhoid (Circle: Intramuscular/Oral) Date _____ **Yellow Fever** Date _____

List all medications you are prescribing for the patient _____

Please describe any current treatment and recommended further treatment _____

Recommendations for intramural/intercollegiate physical activity

- May participate in sports without restrictions
- Should not participate in sports (please explain): _____
- May participate with the following restrictions: _____
- Medical or orthopedic problem must be evaluated before participation is allowed (please explain): _____

PART VI: HEALTH CARE PROVIDER SIGNATURE

Health Care Provider's Name (please print) _____

Address _____
Street City State Zip code Country

Phone () _____ Fax () _____

Signature _____ Date _____

Monsour Counseling & Psychological Services would like to welcome you to our campus!
 This is an exciting time in your life. In order to provide optimum mental health services for all of
 our students, we invite you to complete this optional brief survey.

*Information provided in this survey is confidential and access to any and all information is strictly limited to
 healthcare professionals at Student Health Services and Monsour Counseling & Psychological Services.*

NAME: _____ College _____

Have you experienced, or are you now experiencing, any of the following?
 (Please check **all** that apply)

			Have Received Treatment		Treatment Included:	
	YES	NO	YES	NO	Counseling	MEDS
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental Health Concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you been hospitalized for the above condition(s)? Yes No

Do you plan to continue or to begin receiving treatment? Yes No

MCAPS (on campus) Other Mental Health Professional (off campus)

*If you would like to be contacted by a staff member at MCAPS after the fall semester begins, please
 indicate your preferred contact information here (cell phone or email):*

*Please note: _____
 Only give your contact information if you wish a staff member at MCAPS to contact you.
 Also please remember the security of email cannot be guaranteed, and as such it is not a confidential
 mode of communication.*

PLEASE RETURN COMPLETED FORM TO:
 Student Health Services
 757 College Way
 Claremont, CA 91711
 FAX (909) 621-8472



ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

The complete Notice of Privacy Practices is also posted in our waiting room and our website for your review. If you need a copy at any time our front desk staff can provide it to you.

By signing this form, you are acknowledging that Student Health Services has provided a copy to you, and has made our Notice of Privacy Practices available to you for you to review. The law does not require you to sign the "acknowledgment of receipt of the notice."

Refusing to sign will not affect a patient from receiving medical treatment.

Name (print) _____ Date of Birth __/__/____

Signature: _____

Date: _____



Janet Smith Dickerson -VP of Student Affairs

909-621-8355

Kristi Martinez-HIPAA Compliance Officer

909-607-8857

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical clinic properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. If you have any questions about this notice, please contact our privacy officer above.

A. How Student Health Services May Use or Disclose Your Health Information

B. When Student Health Services May Not Use or Disclose Your health Information

C. Your Health Information Rights

1. Right to Request Special Privacy Protection.
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper or Electronic Copy of this Notice

D. Changes to the Notice of Privacy Practice

E. Complaints



A. How This Student Health Services May Use or Disclose Your Health Information

The Medical record is the property of the medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purpose:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipient of healthcare information from further disclosing it except as specially required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contract of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.



4. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over our objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
5. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use of disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
6. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; report child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
7. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections licensure and other proceedings, subject to the limitations imposed by federal and California law.
8. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
9. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.



10. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of death.
11. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
12. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
13. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
14. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
15. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
16. Changes of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
17. Breach Notification. In the case of breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
18. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following; (1) your treatment, (2) to train our staff, (3) to defend SHS if you sue us or other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.



B. When Student Health Services May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restriction on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning healthcare items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reason. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are requesting because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.



4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information, if we did not create the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with the decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosure. You have a right to receive an accounting of disclosure of your health information made by this medical practice, except that this medical practice does not have to account for the disclosure provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 4 (notification and communication with family) and 14 (specialized government functions) of Section A of the Notice of Privacy Practices or disclosures for purpose of research or public health which excludes direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or a law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.



E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practice.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)

The complaint form may be found at <https://www.hhs.gov/hipaa/filing-a-complaint>. You will not be penalized in any way for filing a complaint.