NOTICE OF PRIVACY PRACTICES

STUDENT HEALTH SERVICES

Effective Date: November 6, 2001

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.

This section of the Notice of Privacy Practices (NPP) provides a brief summary of the privacy practices of Student Health Services and your privacy rights. Please read the entire document for a full description of our practices and your rights. If you need more information, you may call (785) 864-9325.

Our responsibilities regarding your medical information.

Each time you utilize Student Health Services, a record is generated. This record contains medical information about you. Student Health Services is required by law to protect the privacy of your medical information, provide you with the NPP, abide by the terms of the NPP currently in effect, and notify you if we are unable to agree to a requested restriction on use or disclosure of your medical information.

Uses and Disclosures of Protected Health Information.

a. You will be asked to sign a written consent that enables Student Health Services to use and disclose your medical information for treatment (such as sending medical information to a physician we refer you to), payment (such as sending a bill to your insurance carrier), and operations (such as registering you for services). Student Health Services may also contact you regarding your appointments or prescriptions to tell you about health-related benefits or services. In certain limited circumstances Student Health Services may disclose medical information about you to a friend or family member involved in your care.

b. Under certain circumstances, uses and disclosures without your written consent or authorization may take place. For example, Student Health Services may disclose information about you when there is an emergency or a communication barrier, for public health purposes, for health oversight activities, as required by law, for research studies (as permitted by law), and for law enforcement/legal proceedings.

Your Rights Regarding Your Medical Information.

You have the right to inspect and copy your medical information, request an amendment of medical information you believe to be incorrect or incomplete, request accounting of non-routine disclosures, request restrictions on uses and disclosures, request special confidential communications, and receive a written copy of this NPP. You may file a complaint by contacting our Privacy Officer at 864-9325. Student Health Services reserves the right to make changes to this NPP. Any changes will be posted in Watkins Memorial Health Center and on our website: www.ku.edu/shs/

Each time you visit Student Health Services, a record of your visit is made. This record typically contains medical information about you, including information regarding symptoms, observations, assessments (including test results, diagnoses, treatment, and mental health), a plan for future care or treatment, and billing-related information. This NPP describes how Student Health Services may use and disclose your medical information. It also describes your rights and responsibilities regarding the use/disclosure of your medical information. This NPP applies to all of the records of your care generated by Student Health Services.

Student Health Services is required by law to protect the privacy of your medical information, provide you with this NPP, abide by the terms of the NPP currently in effect, and notify you if it is unable to agree to a requested restriction on use or disclosure of your medical information.

1. USES AND DISCLOSURES WITH YOUR WRITTEN CONSENT

You will be asked to sign a written consent form enabling Student Health Services to use and disclose your medical information for treatment, payment, and health care operations as described in this section.

a. Treatment. Student Health Services will use and disclose medical information about you to provide and coordinate your health care and any related services. For example, the information will be used by all members of the staff that are involved in your treatment, including but not limited to physicians and nurses, to coordinate the different services you may need. In addition, your medical information may be provided to another health care provider, such as a physician, to whom you have been referred to ensure that they have the necessary information to diagnose and treat you. Student Health Services may also contact you to tell you about possible treatment alternatives.

b. Payment. Student Health Services will use and disclose medical information about you to bill and collect payment from you, your insurance company or a third party payer. For example, Student Health Services may need to give your insurance company information about your visit to determine coverage and/or coordinate payment for your treatment. If you have any questions regarding the privacy practices of your insurance company or third party payer, you should contact them directly. Student Health Services may respond to inquiries of a family member involved in paying for your care by providing them with very limited information, but not specific details regarding your care. We will share only an amount owed and if it was for a medical visit or prescription, but not the type of visit or medication dispensed.

c. Health Care Operations. Student Health Services will use and disclose medical information about you to schedule and coordinate your health care and related services. Student Health Services may disclose information to doctors, nurses, medical students, and/or residents for educational purposes. Members of Student Health Services staff involved in quality improvement may use information in your health record to assess the care and outcomes in your case and others like it. For example, Student Health Services may analyze medical information about many patients to evaluate the need for new services, resources, or treatment and to see where we can make improvements. The results will then be used to continually improve the quality of care for all patients we serve. If you are a student at the University of Kansas, Student Health Services may release limited medical information to authorized staff of the University to verify receipt of certain tests or vaccinations required for you to be
enrolled at the University or in a specific field of study.

Student Health Services may also contact you to remind you that you have an appointment, to tell you that your appointment has been cancelled or to let you know that your prescription is ready, to assess your satisfaction with our services, to tell you about health-related benefits or services, or to complete the process of registering you for services.

d. Other Related Uses and Disclosures. Student Health Services may use and/or disclose medical information:

- To business associates, when we have contracted out for services, so that they can perform the job we’ve asked them to do, and to bill you or your third party payer for services rendered;
- To a friend or family member who is involved in your care. If you are not present and able to agree or object, such communications shall be made only by authorized healthcare providers when, in their professional judgment, such disclosure is in your best interest.

2. USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

In certain situations, Student Health Services may use or disclose medical information about you without your consent or authorization, for example, when there is an emergency or when there are substantial communication barriers to obtaining consent from you. Further, Student Health Services may use or disclose your medical information without your consent or authorization in the following circumstances:

a. As Required by Law. Student Health Services may use and disclose medical information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public health authorities or legal authorities charged with tracking, preventing or controlling diseases (e.g., STDs, HIV), injuries or disabilities
- Workers compensation agents
- Military command, national security or intelligence authorities
- Health oversight agencies

b. Law Enforcement/Legal Proceedings. Student Health Services may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

c. Research. Student Health Services may disclose medical information to researchers when their research has been approved by an institutional review board.

that has reviewed the research proposal and established protocols to ensure the privacy of your medical information.

3. OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION BASED ON YOUR AUTHORIZATION.

Other uses and disclosures of medical information not covered by this NPP or the laws that apply to Student Health Services, will be made only with your written permission. If you provide Student Health Services with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

You have the following rights regarding medical information we maintain about you:

- Right To Inspect and Copy. You have the right to inspect and have copied medical information used to make decisions about your care. Usually, this includes medical and billing records, but does not include some records such as psychotherapy notes. Your request must be submitted in writing on a form Student Health Services will provide to you. A fee may be charged for the costs of processing your request.
- Right To Amend. If you feel that medical information Student Health Services has about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment to your record, you must submit your request in writing on a form Student Health Services will provide to you. You will be asked to provide a reason to support the request.
- Right to an Accounting of Disclosures. You have the right to receive a list of disclosures. This list will not include all disclosures made. For example, this list will not include disclosures for treatment, payment, health care operations, disclosures made prior to April 14, 2003, or disclosures you specifically authorized. To request this list you must submit your request in writing on a form Student Health Services will provide to you.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information Student Health Services uses or discloses about you for treatment, payment or health care operations. Student Health Services is not required to agree to your request. If the request is approved, Student Health Services will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing on a form that Student Health Services will provide to you.
- Right to Request Confidential Communications. You have the right to request that Student Health Services communicate with you about medical matters in a certain way or at certain locations. You must make your request in writing on a form that Student Health Services will provide to you. Student Health Services will accommodate all reasonable requests.
- Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this NPP, and you may ask Student Health Services to give you a copy of this NPP at any time. You may obtain a copy of this NPP at our website: www.ku.edu/~shs/ You may obtain a copy of the forms mentioned above by contacting the Records and Registration Department at: 864-9500.

If you believe your privacy rights have been violated, you may file a complaint with Student Health Services by contacting the Privacy Officer for Student Health Services at (785) 864-9525 or by contacting the University's HIPAA Privacy Officer, Lawrence Campus, at (785) 864-9528. You may also contact the Secretary of Health and Human Services. There will be no retaliation for filing the complaint.

Student Health Services reserves the right to change this NPP and the revised NPP will be effective for information Student Health Services already has about you as well as information received in the future. Should our practices change, Student Health Services will post a revised NPP on the Student Health Services website and in the facility where you receive services. Paper copies will be available upon request.

If you have any questions about this notice, please contact our Privacy Officer at (785) 864-9323.
CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide you information about how Student Health Services can use or disclose your medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent.

By signing this Consent form, you: (1) Acknowledge that a copy of the NPP has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_________________________________________  __________________________
Patient's Name (Printed)                          KUID/SS#

_________________________________________
Signature of Patient or Personal Representative  Date

Personal Representative’s relationship to Patient: _________________________________

_________________________________________
Personal Representative’s Address and Phone Number:

_________________________________________

_________________________________________

DO NOT WRITE BELOW THIS LINE

documentation of Good Faith Effort

Check the applicable box showing Good Faith Effort.

☐ Emergency situation. Provide patient with copy of NPP as soon as reasonably practicable after the emergency treatment situation.

☐ Patient/Legal representative given NPP, but declines to acknowledge receipt.

☐ Patient/Legal Representative states that they have already received the NPP.

☐ Other: ________________________________________________

_________________________________________  __________________________
Employee Name (Printed)                          Date

_________________________________________
Signature of Employee

WATKINS MEMORIAL HEALTH CENTER 03/03

THE UNIVERSITY OF KANSAS
CONSENT TO TREATMENT
1. I hereby consent to such health care as may be deemed necessary by the providers in Student Health Services (SHS), University of Kansas, Lawrence, KS, including x-ray examination, lab tests, administration of medications, and any other diagnostic or therapeutic treatments.
2. I understand that SHS is a teaching health facility and that students and residents acting under the supervision of licensed clinical staff may be involved in my care. I understand that I may decline service by the student or resident.

GENERAL CONDITIONS FOR TREATMENT BY STUDENT HEALTH SERVICES
3. I understand that I should fully participate in my care by asking any questions about my condition or treatment.
4. I understand that SHS is not responsible for loss or damage to clothing, jewelry or other valuables in my possession.
5. I acknowledge that the use of any video capturing devices (cameras, cell phones, etc.) by other than authorized personnel for official business is prohibited.
6. I understand that treatment / services will not be provided while I am using a cell phone.

INSURANCE ASSIGNMENT
7. I hereby assign all benefits payable under the terms of my insurance policy/healthcare coverage to SHS, and I authorize payment directly to SHS for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I understand that if my healthcare coverage changes, I am to notify SHS Business Office.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY
8. I understand that SHS does not contract with all insurance companies and it is my responsibility to know if my insurance plan provides coverage for SHS services or requires a referral or pre-approval for such services.

9. Further, I understand that SHS is not a contracting provider for and cannot bill Medicare, Medicaid, or Healthwave. If I have these types of government healthcare benefits, I am responsible for paying all SHS charges and it is my responsibility to seek reimbursement from these programs.

10. I understand that I am financially responsible to SHS for any charges, copays and deductibles not covered by my insurance company/health plan. If I do not want my insurance company/health plan billed or a statement sent for charges, it is my obligation to immediately advise the SHS Business Office. I understand that I may address any questions concerning my charges, coverage, billing or payments, to the SHS Business Office.

A copy of this document shall be as valid as the original.

Print Patient Name

Date: ____________ KU ID#_________

Signature (Patient, Agent or Representative) Relationship to Patient

Print Name of Agent or Representative (patient label)

_________________________
AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I. ____________________________, hereby authorize _______________________, (name of parent or guardian) _______________________, (name of representative) _______________________, and/or _______________________, (name of representative) _______________________, members of the Jayhawk Deaconess Institutional/Departmental staff _______________________, (name of representative) _______________________, to give consent for treatment for my child, _______________________, (name of child) _______________________, in the event of illness or injury. This authorization is effective from _______________________, (date) _______________________, to _______________________, (date) _______________________.

Our child's doctor is _______________________, (name of doctor) _______________________, and our child's address is _______________________, (address) _______________________, our insurance name is _______________________, (insurance name) _______________________, our policy number is _______________________, (policy number) _______________________, and our insurance provider is _______________________, (insurance provider) _______________________.

List of current medications and dosages: (If none, write none) _______________________, (list of medications and dosages) _______________________, allergies: (If none, write none) _______________________, (allergies) _______________________, medical history: (If none, write none) _______________________, (medical history) _______________________, date of last tetanus shot: _______________________, (date of last tetanus shot) _______________________, insurance name: _______________________, (insurance name) _______________________, policy number: _______________________, (policy number) _______________________, insurance provider: _______________________, (insurance provider) _______________________.

(Signature of parent or guardian) _______________________, (signature) _______________________, (date) _______________________, (notary signature) _______________________, (commission) _______________________.
CONFIDENTIAL MEDICAL RECORD

Name of Camp: ________________________________

This completed form must accompany the camper on their first health center visit. It is essential that consent for treatment of a minor is signed by a parent or guardian.

Camper’s Name ________________________________ Birth Date ___________ Sex ______ SSN ___________

Parent Name ________________________________ Parent SSN ___________ Home Phone ___________

LAST FIRST MIDDLE

Address ______________________________________

Person to notify in case of emergency, if other than above: Name ______________________________________

Day Phone ___________ Night Phone ___________ Address ______________________________________

Phone # __________________

Name of Family Physician ______________________ Phone # __________________

1. Does camper have any significant illness or disability? ☐ YES ☐ NO If yes, please explain, ______________________________________

2. Please check if camper has or has had any of the following: ☐ asthma ☐ chicken pox ☐ diabetes ☐ epilepsy ☐ kidney problems
   ☐ polio ☐ rheumatic fever ☐ tuberculosis ☐ other ____________

3. Has camper had any other significant illnesses, injuries, or surgeries? ☐ YES ☐ NO If yes, please explain ______________________________________

4. What routine medications & their dosages does the camper take? ______________________________________

5. Date of last tetanus/diphtheria: ______________________ Date of last MMR: ______________________

6. Is camper allergic to any medications? ☐ YES ☐ NO If yes, please list ______________________________________

7. Does camper have any other allergies? ☐ YES ☐ NO If yes, please list ______________________________________

HEALTH INSURANCE BILLING INFORMATION

Please note: (1) If any charges are to be billed to an insurance company, a copy of the camp participant’s insurance card(s) must also be provided during the visit. (2) We cannot bill Medicaid, Medicaid or Healthwave as we are not participating providers with these programs.

Insurance Company ________________________________

Claim Form Address ______________________________________

I.D. No. ______________________ Group No. ______________________ Name of Policyholder ______________________

Address of Policyholder ______________________________________

I hereby authorize Student Health Services to disclose to the above named insurance company, information from the camper’s medical record as needed in presenting my claim for benefits.

Camper’s signature ________________________________ Date ______________________

Parent’s signature ________________________________ Date ______________________

CONSENT FOR TREATMENT OF A MINOR

I hereby give my consent for treatment of: ______________________ Last _______ First _______ Middle ________ Birth Date ________

This authorization covers any procedure, which may be deemed advisable by the attending staff physician.

Signature of person authorized to give consent for camper treatment ______________________ Relationship to camper ____________ Date ____________

Rev. 03/06
Jayhawk Debate Institute
Memorandum of Understanding

As a student of the Jayhawk Debate Institute, I agree to adhere to all rules, regulations, and policies of the University of Kansas, the KU Department of Student Housing, and the Jayhawk Debate Institute. I understand that a violation of the rules may result in a denial of privileges, confinement to my dorm room or expulsion from the institute in violation of the guidelines.

I understand that the following are typical of the acts or situations that will result in automatic expulsion from the Institute:

1. Consumption of alcoholic beverages, illicit substances, or non-approved prescription drugs. Use of prescription drugs must be approved by the Institute Director prior to the beginning of the Institute. The presence of a substance on the person of, among the belongings of, or in the dorm room of an institute student will be considered as possession by that student.
2. Damage to University property. This includes destruction or damage of any facilities including, but not limited to, dorm rooms, classroom buildings, libraries, cafeteria, and recreational areas. This also includes theft or damage to any library materials.
3. Violation of curfew. No student will be allowed outside the dormitory after curfew without the expressed permission of the Institute Director or Associate Directors.
4. Theft. This includes theft of other's personal belongings and debate materials.
5. Presence outside the campus perimeter. The student may not leave the University campus proper unless he or she has the expressed permission of the Institute Director accompanied by written parental permission. The campus perimeter will be clearly delineated to the students at the beginning of the Institute. This rule includes the use of unauthorized vehicles. Students should not use public taxis, busses or any other vehicles to leave campus.

I understand that the following are typical of the acts or situations that may result in expulsion from the Institute or other disciplinary action. Repeat offenses will result in expulsion from the Institute.

1. Presence in restricted areas of the dormitories. No student is permitted in the hallways or personal rooms in the dormitories of the opposite gender. Floors where other camps are housed and other dormitories are also restricted. A student would also be in violation if he or she invited members of the opposite sex into their dorm room. Students are permitted on the main lobby and individual lobbies of the floors in the dormitory the Institute has students.
2. Failure to attend assigned classes, lectures, and activities. Attendance at Institute functions is mandatory for all students.
3. Conflicts with other students involving physical or verbal abuse. This includes placing another student's life in danger or threatening to do so.
4. Violations of other rules, regulations, or policies as announced by the Institute Director or dormitory directors during the course of the Institute or described elsewhere in this mailing.
5. Failure to show respect for Institute staff members including failure to comply with staff member requests, instructions, etc.
6. Violation of the institute smoking policy and/or requests for those eighteen and over to move to designated smoking areas.

I understand that I am subject to the policies of the Institute from the time I enroll in the Institute until the time I officially check out of the Institute. By signing below I acknowledge acceptance of these rules and affirm that I have thoroughly familiarized myself with the contents of this mailing and the rules therein.

| Signature of Student | Date | Signature of Parent/Guardian | Date |
I give permission for (insert student’s name) to leave the University of Kansas campus and the Jayhawk Debate Institute with the following individual(s) on the following dates at the following times:

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If you are not certain about departure or return times, please include the best information you have at this time and notify the Institute Director with more accurate information as soon as possible. For liability reasons, written permission is essential.

In signing this form, I understand that the University of Kansas and the Jayhawk Debate Institute are not responsible for the student while he or she is away from the Institute and take full responsibility for his or her well-being and whereabouts.

__________________________  ________________________
Signature of Parent/Guardian  Date