University of Puerto Rico

Río Piedras Campus

Department of Medical Services

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 Name of student Student number

**NOTIFICATION OF USE AND AUTHORIZATION OF disclosure of health information**

The federal law Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Charter of Patients’ Rights and Responsibilities require orientation and consent regarding the use and disclosure of your protected health information previous to providing the solicited health services.

As health service providers, the Department of Medical Services (DSM) and its personnel have the obligation to protect and safeguard the confidentiality of your health information. This information, compiled in your medical record, includes: medical history, test results, diagnostic tests results, symptoms, treatments, and plan of care. This information can be used for: a) planning your care plan and treatment, b) communication between the professionals participating in your treatment, c) as an information resource to determine a medical-surgical diagnostic, d) for purposes of billing and auditing for the utilization of services by your health insurance provider, and/or for auditing purposes of quality and effectivity of services.

By signing this form, you authorize the DSM, through its personnel and business associates, to use your health information and disclose it within the legally permitted parameters, listed above. The same is not applicable for requesting a copy, partial or total, of the medical record and/or disclosure to third parties. For these disclosures, you must complete the corresponding authorization forms.

If interested in examining in a detailed manner the Privacy Policy of the DSM you can access it under the section *documentos y formularios* (documents and forms) of the DSM webpage and/or solicit it from DSM personnel.

I certify I have read this authorization’s provisions, that I understand, and that I agree with the terms and conditions expressed in it.

**Student’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student date and place of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\* Signature of parent or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\* Name of parent/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\* Relationship with the student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date (*mm-dd-yyyy*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*Required for patients younger than 21 years of age, not emancipated. Forms signed by emancipated minors or legal guardians, must be presented with evidence accrediting the emancipation or legal guardian’s assignment. This evidence has to be apostilled if not granted in Puerto Rico.

\* This authorization is required and will be in force until your student reaches his/her 21st birthday.