University of Puerto Rico
Río Piedras Campus
Medical Service Department

_____ _____

PATIENT'S NAME **STUDENT NUMBER**

Consent to use or publish health information for Treatment Purposes, Payments and Departmental Operations

The Federal Health Insurance Portability and Accountability Act of 1996 and The Patients´ Rights and Obligations Chart requires that, in order to provide services, obtain a written consent from patients for the use or disclosure protected health information for the purpose of treatment, payment and other transactions or administrative operations related to the health care provided by our Department.

Patients must understand that, as part of the health care provided the Medical Services Department originates and maintains patients´ health records containing medical history, test results, symptoms, diagnostic tests, treatments and health care plans. This information can be used to a) plan the patients health care or treatment; b) as a means communication among professionals treating the patient; c) as a source of information in medical and surgical diagnosis; d) during the service usage auditing procedures of the health insurance companies; e) during the auditing of the quality and effectiveness of the services.

By signing this consent, you authorize the Medical Service Department, its employees (in compliance with HIPPA, this includes regular employees and any voluntary personnel working for the organization) and their business associates, the use and disclosure of the patients´ protected health information for treatment, payment, transactions and administrative operations related to their health care.

Patients have the right to revoke this consent in writing, except in the case that the Department, its employees and/or business associates have used the information in any action and/or disclosure based on it.

The first time patients receive services, they will receive a copy of our Privacy and Confidentiality Policy. If you wish to examine the policy more carefully, you may obtain a copy from the Department's Privacy Official.

This consent will become effective the moment the patient requests and receives medical treatment from this Department.

I certify that I have read the dispositions of this consent and that I understand and agree with its terms and conditions.

_____ _____

Patient's Signature **Parent or Legal guardian's signature**

_____ _____

Parent or Legal guardian's name **Date**

NOTE: If the patient is under 21 years old and is not emancipated, this document has to be signed by him/her as well as by his/her parents. If the consenting adult is a tutor or divorced parent with no custody, judgment of the court is needed as evidence of *patria potesta* (parental authority) over the minor.