NOAH CAMPUS HEALTH
CLINIC
a department of Waverly Health Center

Agreement for Shared Information
Health Information Privacy and Security Policy
Acknowledgement for Receipt of Notice of Privacy Practices

I consent to the release of my protected health care information for purposes of carrying out treatment, payment and performing health care options. I have the right to request restrictions on how my protected health care information is released for the purposes of carrying out treatment, payment or performing health care options. I understand that Wartburg College/Noah Campus Clinic has no obligation to agree to such restrictions. It is the policy of Wartburg College and the Noah Campus Clinic to comply with all federal and state laws and regulations that require personal health information of our employees and/or students to be kept confidential and private.

Wartburg College and the Noah Campus Clinic are committed to protecting the privacy and security of personal health information concerning our employees and students. This policy is designed to assure Wartburg College and the Noah Campus Clinic's compliance with all applicable federal and state laws and regulations that require an individual's personal health information to be kept confidential and private.

Applicable Laws and Regulations:
Iowa Code Chapter 22.7(2) and 228.
FERPA (Family Educational Rights and Privacy Act) 20 U.S.C. 1232(g) and 34 CFR Part 99.
HIPAA (Health Insurance Portability and Accountability Act) 42 U.S.C. 1320 (d) and 45 CFR Parts 160 and 164.

I acknowledge that the Notice of Privacy Practices for Wartburg College and the Noah Campus Clinic has been made available to me.

I agree that Wartburg College can share health information with the Noah Campus Health Clinic, and that the Noah Campus Health Clinic can also share health information with Wartburg College.

Print Name: _____

ID#: _____ DOB: _____

Campus Box: _____ Personal Phone#: _____

_____
Signature

_____
Signature of parent/guardian (if student is under the age of 18):

Date: _____

Note: If the information includes mental health treatment, substance abuse treatment, or HIV related information, it will not be released unless you agree to the release on the reverse side of this form.

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Specific Authorization for Release of Information Protected by State or Federal Law

I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and or HIV-related information. I specifically authorize the release of information relating to:

- □ Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV) infection
- □ Mental health treatment
- □ Substance abuse treatment

_____

Signature of the Patient/Personal Representative Date Signed

_____

Relationship to Patient

Federal and/or State law specifically require that any disclosure or redisclosure of substance abuse, mental health, or HIV-related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.