Mary Baldwin Health Center
CONFIDENTIALITY FORM

Name _____ **Student ID #** _____

This is to acknowledge that a copy of the HIPAA notice of privacy practices has been made available to me. I understand how medical information about me may be used and disclosed and how I can get access to this information.

This notice became effective April 14, 2003.

I give the staff at the Mary Baldwin Student Health Center permission to disclose general medical information to the following people:

List full name(s) below and include phone numbers when possible. You may include anyone such as parents, siblings, friends, college faculty or advisors, Student Life, significant others, etc.

If you are 18+ we are NOT able discuss your healthcare with any personal contacts who are NOT on this list.

*This form should be updated MORE than once a year should any changes in relationships occur and you no longer want your health information potentially shared with the person(s) below.

1. _____ (_____)_____
2. _____ (_____)_____

STUDENT CONTACT INFORMATION

I may be contacted in the following ways to get limited health information: PLEASE WRITE CLEARLY

Cell _____ ☐ Check if a message can be left on Voicemail - **NO TEXTS!**

Email _____ ☐ Check if a message can be delivered via Email

Name of Residence Hall: _____

_____ _____
Patient Signature **Date**

OFFICE USE ONLY

2nd yr Information Updated Date: _____ Patient Initial: _____ Dorm: _____

3rd yr Information Updated Date: _____ Patient Initial: _____ Dorm: _____

4th yr Information Updated Date: _____ Patient Initial: _____ Dorm: _____