

Ithaca College Student Health Services, 953 Danby Rd., Ithaca, NY 14850

Privacy Official: 607-274-3177

Please review out “[Notice of Privacy Practices](#)” which describes how medical information may be used and disclosed and how you can get access to this information.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the “[Notice of Privacy Practices](#)” of the medical practice names at the top of this page. Please complete this notice of privacy practices receipt and sign both the receipt and the consent below.

Print Name of Student: _____

Student’s Ithaca College ID: _____

Student’s Date of Birth: _____

Date: _____

Please check if you are under 18: ☐

For Personal Representative of the Student (if a minor):

Print Name of Personal Representative: _____

Describe Personal Representative
Relationship (parent, guardian, etc.): _____

Signature of Personal Repetitive: _____

Date: _____

Consent for Purposes of Treatment, Payment, or Health Care Operations

I consent to the use or disclosure of my protected health information by the Ithaca College student health services staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or discolored for the above purposes. The Ithaca College Hammond Health Center is not required to agree to such request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The “[Notice of Privacy Practices](#)” describes my rights as well as Ithaca College Hammond Health Center’s rights and responsibilities with respect to my protected health information.

Signature of Student (or personal representative if a minor): _____

Name of Student: _____

Date: _____