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|  | **THE UNIVERSITY OF WEST ALABAMA**  **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION** | REVISED 07/15/18 |

**PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the date of your signature on the CONSENT for USE AND DISCLOSURE OF HEALTH INFORMATION FORM and will remain in effect until we replace it.

Participants in The University of West Alabama's athletics programs are students; therefore, their medical records are student treatment records. Their health care information falls under the Family Education Right to Privacy Act (FERPA) Regulations. Student treatment records are specifically excluded from the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements. But, the following privacy practices will ensure that information contained in the medical records will be protected per the requirements of both Acts.

We reserve the right to change our privacy practices and the applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for prevention, evaluation, treatment, rehabilitation, and referral of injury/illnesses, as well as healthcare operations. We also use and disclose healthcare information to the appropriate personnel for the payment of any bills incurred in the care of any athletic injury/illness you sustain. We also may use and disclose information to our sports information director for communication with the public media. Further detailed examples of use and disclosures are as follows:

Prevention, Evaluation, Treatment, Rehabilitation, and Referral: We may use or disclose your health information to a physician or other Allied Healthcare provider that potentially may be providing any of the listed to you. We may also use or disclose your health information to our coach or coaches, our director of athletics, the university president, the university attorney, or any member of the athletic training or sports medicine staff director of athletic training and sports medicine, head athletic trainer, athletic trainers, graduate assistant athletic trainers, athletic training students, and team physicians).

Payment: We may use and disclose your health information to appropriate university personnel responsible for payment of healthcare/insurance claims. We may also use and disclose your health information to carry out payment through our insurance company.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing, activities.

Our Authorization: In addition to our use of your health information for prevention, evaluation, treatment, rehabilitation, and referral of injury/illnesses, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to any one for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use or disclose health information to notify; or assist in the notification of (including identifying or­ isolating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written Authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Professional Sports: With your written permission, we may disclose your health information to scouts or representatives of professional sports organizations.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Alternative Treatments: We may use or disclose your health information to provide you with treatment alternatives or services related to your health. You will have an opportunity to refuse to receive this information.

Worker's Compensation: Your health information regarding benefits, for work-related injury/illness may be released as appropriate.

Health Oversight Activities; we may use or disclose your health information for audits, inspections, or investigations.

Projects: We may use or disclose your health information, with your consent, for the purpose of preparing research or case study projects.

Other ways the Athletic Training and Sports Medicine Staff May Use Your Medical Information:

* To prevent a serious threat to health or safety
* For law enforcement in response to a court order or other legal process
* Disaster relieve agency if you are injured in a disaster situation
* National security and intelligence activities
* Lawsuits and disputes (We will attempt to provide you advance notice of a subpoena before disclosing any information)
* Anytime as required by law

**Patient Rights**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before the date(s) of service.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Website or by electronic mail (e mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMMENTS.**

If you want more information about our private practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Officer: Brad Montgomery

Station# 14, UWA

Livingston, AL 35470

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|  | **THE UNIVERSITY OF WEST ALABAMA**  **CONSENT FOR USE AND DISCLOSURE.OF HEALTH INFORMATION** | REVISED 07/15/18 |

**SECTION A: PATIENT GIVING CONSENT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Name: |  | | | | | | | | | | | | | | |
|  | (Last) (First) (Middle) (Nickname) | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | |
| Street or P.O. Box | | | | | | | | | | (City) (State) (Zip Code) | | | | | |
| Home Phone: | | | | ( |  | | | ) |  | Business Phone: | | ( |  | ) |  |
| Cell Phone | | | ( |  | | ) |  | | | e-Mail: |  | | | | |

**SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out prevention, evaluation, treatment, rehabilitation, and referral of injury/illnesses, as well as, healthcare operations. Your signature also confirms the fact that a copy of the Notice of Privacy Practices was provided for you.

Notice of Privacy Practices: You have the right to read our Notice of Privacy practice before you decide to sign this Consent. Our Notice provides a description of our prevention, evaluation, treatment, rehabilitation, and referral of injury/illnesses, as well as, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Brad Montgomery

Station# 14, UWA

Livingston, AL 35470

Office:205-652-3639 Fax: 205-652-3799 Email: bsm@uwa.edu

I grant permission for the University of West Alabama Athletic Training and Sports Medicine Staff to disclose and any and all protected health care information to the following individual(s).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print name: |  |  | Relationship to me: |  |
| Print name: |  |  | Relationship to me: |  |
| Print name: |  |  | Relationship to me: |  |
| Print name: |  |  | Relationship to me: |  |

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE:**

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

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| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

If a minor signs this consent, a parent or guardian must sign below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent or Guardian's Name:** | |  | |
|  | | | (Last) (First) (Middle) (Nickname) |
| **Relationship to Patient:** |  | | |
|  |  | | |

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| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**

**Include completed Consent in the patient's chart**