

# FOR USE AT FLU VACCINE CLINIC

## CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

In our Notice of Privacy Practices (NPP) we provide you information about how Student Health Services can use or disclose your medical information. As described in our NPP, we request your consent for any use or disclosure of medical information to carry out treatment, payment, or health care operations. You have a right to review our NPP before signing this Consent.

By signing this Consent form, you: (1) Acknowledge that a copy of the NPP has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the NPP.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
KU ID

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date