EMORY UNIVERSITY | Student Health Services
Campus Life

Consent to Disclosure of Personally Identifiable Information

Emory University Student Health Services (EUSHS) and Oxford Student Health Services (OXSHS) student-patient's records are covered by the Family Educational Rights and Privacy Act (FERPA). Under FERPA, EUSHS/OXSHS is permitted to use and disclose the Personally Identifiable Information that it collects about you to health care providers in order to provide you with treatment. EUSHS is also permitted to use and disclose personally identifiable information from your Education Records for legally permitted purposes, including business operations and public health purposes. Aside from these permissible disclosures, FERPA requires EUSHS to obtain your written consent to disclose personally identifiable information from your education records for other purposes.

By signing this form, I consent to permit EUSHS to use and disclose to the following persons/entities, and for the purposes described below, the Personally Identifiable Information that it collects or generates about me and my health and health care. This information includes, but is not limited to, clinical visit notes; diagnoses; types or results of tests or procedures performed; and prescribed medications or therapies:

Person/Entity to Whom Information will be Disclosed	***Type of Information***	***Purpose of Disclosure***
[To be completed as needed]		
Insurers and or government programs that provide medical benefits (e.g., Medicare, Medicaid).	Information pertaining to health and health care that is necessary to submit claims for benefits.	To provide information necessary to request and receive payment for treatment items and services provided by EUSHS.

I agree that if the health information that I have provided consent to disclose contains any communications that are considered privileged under applicable laws related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), immunodeficiency syndrome related complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory University, its facilities, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

You may withdraw this consent at any time by sending a signed, written request to: Emory University Student Health Services Business Office, 1525 Clifton Road NE, Atlanta, GA 30322 or Oxford Student Health Services

Business Office, 104 Moore Street, Murdy Residence Hall, Oxford, GA, 30054. Any information that has been disclosed prior to your withdrawal will not be affected.

Agreed to:

Signature: ____ Date: ____________________________

Student ID Number: ____

Printed name: ____

If the student is under the age of 18, the signature of the student and the student's parent or guardian is required.

This signature is ***in addition to, and not a replacement for***, the student's signature above with regard to consent under FERPA:

Agreed to:

Printed Name: ____________________________________ Date: _______________________________

Relationship to student: ____

Printed Name: ____

Updated 6/24/2024

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