

# Plattsburgh State

## Consent for Treatment, Payment and Health Care Operations

\_\_\_\_\_  
Patient/Client Name

\_\_\_\_\_  
Identification Record Number

In providing service to you, we create and store health information that identifies you. We understand that this information about you and your health is personal, and we are committed to protecting the privacy of this information. We must obtain your written consent before we treat you, obtain payment or provide services, and conduct health care services of the university. *Please read carefully the information below before signing this form.*

**Scope of Consent:** By signing this consent form, you will permit SUNY Plattsburgh's \_\_\_\_\_ and its staff to use your protected health information for treatment, payment and normal business operations with the university. You also permit the University and its staff to share your information with other persons or organizations outside the University that perform payment activities and business operations jointly with the University.

**Notice of Privacy Practices:** We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail and we encourage you to read it. We want you to know, however that the Notice of Privacy Practices is subject to change. If it is changed, you may obtain a copy of the revised notice by accessing the University's web site at [www.plattsburgh.edu](http://www.plattsburgh.edu) or by calling the Privacy Officer at 564-3289, or asking for a copy at your next visit.

**Restricting Use and Disclosure:** You have the right to ask us to restrict the uses or disclosures of your protected health information. The University is not required to agree to this restriction, but if it does, it will be bound by its agreement unless the information is needed to provide you with emergency treatment or comply with the law.

**Revoking Consent:** You have the right to revoke this consent at any time, except to the extent that the University has provided you with treatment, the University will be permitted to use or disclose your protected health information to bill for that treatment. To revoke this consent, please write to the Privacy Officer, State University of New York.

**I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.**

\_\_\_\_\_  
Signature of Patient/Client or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient/Client

(Initial) [    ] I received/was offered a copy of the "Notice of Privacy Practices".