THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

Claremont Graduate University

Medical History Report

All forms must be submitted to SHS: shsrecords@claremont.edu.

DATE: _____
Month Day Year

Name: _____ **Phone:** _____
Last First Middle

Gender: _____ **Date of Birth:** _____
Month Day Year

Address: _____
Street City State Zip

Person to notify in U.S. in case of an emergency: _____
Name Relationship Telephone

_____
Street City State Zip

Medical Insurance Coverage – Required for all students

To protect against the potential major costs of accident or severe illness, domestic and undocumented students are required to enroll in CGU's Student Health Insurance Plan (SHIP) unless eligible for a waiver. All F-1 international students are required to be enrolled in an Accident and Sickness Plan. Your policy information will be provided by CGU at the beginning of each academic term. ***All students with insurance outside of CGU's plans, please provide your insurance policy information below:***

Insurance Company**:** _____ Policy Number: _____

Phone number for reporting claims: _____

MEDICAL CARE AUTHORIZATION

I, the undersigned, hereby specifically authorize The Claremont Colleges Services Student Health Services health care provider or whomever he or she may designate to administer any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, in serious or major illnesses or injuries without prior notification of the undersigned or any other person and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending health care provider or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. I further agree that the Student Health Services may release any medical information to other campus health care providers at Monsour Counseling and Psychological Services who may be providing care.

SIGNATURE OF STUDENT: All students must sign.

Student Signature: _____ Date: _____

NOTE: A release of information must be signed and dated and on file for students 18 and older before any patient records and/or, billing information may be released/discussed with a student, parent, guardian, spouse, or healthcare provider. A form is available at https://services.claremont.edu/shs/docs/release-of-records-to-provider/ or at Student Health Services.

757 College Way, Claremont, CA, 91711
(909) 621-8222 • (909) 621-8472F

THE CLAREMONT COLLEGES SERVICES

STUDENT HEALTH SERVICES

To be completed by Health Care Provider Only:

Tuberculosis screening

All students from high prevalence areas for tuberculosis, or otherwise high-risk, must have a health care provider complete the form below or submit a report documenting a negative tuberculin skin test, a negative (normal) chest x-ray, or Interferon Gamma Release Assay (blood test) from a health care provider. A student with a positive tuberculin skin test, current or past, must submit a chest x-ray report. The report must be written in English, have the date of the skin test, x-ray, or blood test and have the name and the signature of the health care provider.

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3. ***If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.***

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.

Date Given: ____ /____ /____ Date Read: ____ /____ /____
M D Y M D Y

Result:_____mm of induration Interpretation: positive_____ negative_____

>5 mm is positive if the student has one of the risk factors below

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

Otherwise >10mm is positive

3. Interferon Gamma Release Assay (IGRA) may be used instead of Tuberculin Skin Test if available:

Date Obtained: ____ /____ /____ (specify method) QFT-G QFT-GIT other_____
M D Y

Result: Negative____ Positive____ Intermediate____

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____ /____ /____ Result: normal_____ abnormal_____
M D Y

Continue to next page

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STUDENT HEALTH SERVICES

To be completed by Health Care Provider Only

Immunization Record: (Please fill out below OR attach copy of the immunization record)

Recommended

MMR (measles/mumps/rubella) – dates of vaccine or laboratory report of immunity

_____ #1 _____ #2 _____#3 or Report of Positive Immunity _____
(Persons born before 1957 are considered immune; all others should receive at least one dose of MMR vaccine)

Td or Tdap (tetanus/diphtheria/pertussis) – booster recommended every ten years

Date of last immunization _____

Varicella (chickenpox) – history of disease or dates of vaccine or laboratory report of immunity

_____ #1 _____#2 or Report of Positive Immunity _____ or Date of Disease _____

Hepatitis B --
_____ #1 _____ #2 _____#3

Hepatitis A --
_____ #1 _____ #2

Meningococcal Tetravalent (MCV4) Tetravalent conjugate (preferred) Tetravalent polysaccaride — Date of last immunization _____ Booster _____

Human Papillomavirus (2, 4, or 9 valent)
_____ #1 _____ #2 _____#3

Polio
_____ #1 _____ #2 _____#3 _____ #4 _____ Last Booster

Influenza - Date of last immunization _____

Name of Health Care Provider (Please print): _____

Provider Address:_____
Street ***City*** ***State*** ***Zip***

Provider Phone #: _____ ***Provider Fax#*** _____

Signature of provider: _____ ***Date:*** _____

Stamp of provider:

THE CLAREMONT COLLEGES
SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

The complete Notice of Privacy Practices is also posted in our waiting room and our website for your review. If you need a copy at any time our front desk staff can provide it to you.

By signing this form, you are acknowledging that Student Health Services has provided a copy to you, and has made our Notice of Privacy Practices available to you for you to review. The law does not require you to sign the "acknowledgment of receipt of the notice."

Refusing to sign will not affect a patient from receiving medical treatment.

Name (print) _____Date of Birth __/__/____

Signature: _____
.

Date: _____

THE CLAREMONT COLLEGES
SERVICES

Janet Smith Dickerson -VP of Student Affairs **909-621-8355**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISLCOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical clinic properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. If you have any questions about this notice, please contact our privacy officer above.

A. How Student Health Services May Use or Disclose Your Health Information
B. When Student Health Services May Not Use or Disclose Your health Information
C. Your Health Information Rights
    1. Right to Request Special Privacy Protection.
    2. Right to Request Confidential Communications
    3. Right to Inspect and Copy
    4. Right to Amend or Supplement
    5. Right to an Accounting of Disclosures
    6. Right to a Paper or Electronic Copy of this Notice
D. Changes to the Notice of Privacy Practice
E. Complaints

THE CLAREMONT COLLEGES
SERVICES

A. How This Student Health Services May Use or Disclose Your Health Information

The Medical record is the property of the medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purpose:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipient of healthcare information from further disclosing it except as specially required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contract of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over our objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use of disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

6. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; report child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

7. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections licensure and other proceedings, subject to the limitations imposed by federal and California law.

8. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

9. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

10. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of death.

11. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

12. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

14. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

15. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

16. Changes of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

17. Breach Notification. In the case of breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

18. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following; (1) your treatment, (2) to train our staff, (3) to defend SHS if you sue us or other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing theses notes.

B. When Student Health Services May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restriction on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning healthcare items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reason. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are requesting because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information, if we did not create the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with the decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosure. You have a right to receive an accounting of disclosure of your health information made by this medical practice, except that this medical practice does not have to account for the disclosure provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2 (payment), 3 (health care operations), 4 (notification and communication with family) and 14 (specialized government functions) of Section A of the Notice of Privacy Practices or disclosures for purpose of research or public health which excludes direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or a law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practice.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)

The complaint form may be found at https://www.hhs.gov/hipaa/filing-a-complaint.. You will not be penalized in any way for filing a complaint.