



Thagard Student Health Center
Division of Student Affairs
Florida State University
Tallahassee, FL 32306-2140

(850) 644-6230 • www.tshc.fsu.edu

Healthcare Compliance Information

Florida State University's Thagard Student Health Center (TSHC) is staffed by physicians, nurse practitioners, registered nurses, nutritionists, health educators, and various support personnel to serve your healthcare and health education needs. It is funded in part by some of the fees you pay to FSU. **Website:** www.tshc.fsu.edu

Services Provided

Thagard Student Health Center is a fully accredited primary care center with two general medical clinics, a women's clinic, a nutrition clinic, a physical therapy clinic, a psychiatric clinic, a radiology clinic, an allergy clinic, a travel clinic and a triage clinic. A team of dedicated professionals provides a variety of wellness, minor illness, injury and urgent medical care and outreach programs. Quest Labs is the in-house full service laboratory. Student groups, outreach programs and peer education groups are available.

Payment for Services

TSHC accepts cash, checks, VISA, MC, FSUCard, HSA cards and insurance as payment for services. You may also defer charges to your Student Financial Services (SFS) account; however, doing this will result in a registration HOLD until paid in full. TSHC is an in-network provider for Aetna PPO and selected HMO health plans, most BCBS PPO plans, Humana and United Health Care PPO plans. Claims to other insurance carriers are billed as "out-of-network." Any amount not covered by your insurance plan will be placed on your SFS account. It is the student's responsibility to know what his/her individual plan coverage is. If you have an HMO insurance plan, your insurance company may require that you have a referral or pre-authorization to be seen at TSHC. Please contact your insurance company prior to scheduling an appointment.

Confidentiality of Records

Medical records are strictly confidential. For patients age 18 and older written consent by the patient is required before records can be released. The authorization for release of medical records must be done on a per-visit or per condition basis and is valid for 6 months (unless the patient specifies a different time frame) or is revoked by the student. **There is no blanket release for students to sign.** Parents or legal guardians of students under 18 have the legal right to review medical records for their children except for issues dealing with birth control and sexually transmitted infections.

Health Compliance Packet:

- Form 1 – Health History Form - SUBMIT
- Form 2 – Student Immunization Record – SUBMIT
- Form 3 – Health Center Patient Disclosure Authorization - SUBMIT
- Form 4 – Privacy Policy – DO NOT SUBMIT
- Form 5 – Vaccine Information Sheet – DO NOT SUBMIT

Effective July 1, 2011. All other editions of these forms are obsolete.

Please Submit Form 1, Form 2, and Form 3 to
Thagard Student Health Center
c/o The Health Center Compliance Office
109 Collegiate Loop, Tallahassee, FL 32306-2140
Ph. 850-644-3608./ Fax 850-644-8958.

Or Use the FSU drop box at <http://dropbox.fsu.edu>
See attachment for instructions on how to submit forms electronically.

Processing the health compliance forms can take up to five days.
It is the responsibility of the student to verify clearance at
<https://admissions.fsu.edu/StatusCheck/>.



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Healthcare Compliance Information

Student Health History Form (Form 1)

Section A: Please complete entirely to include, Full Name, DOB, FSUSN or FSUID, Complete Address, Phone (Home and Cell) and email.

Section B: Please complete all three questions as they apply to you.

Section C: Please initial the sections for Student Observers and Notice of Privacy Policy (Form 4) to acknowledge understanding and receipt of these two policies. **YOU MUST SIGN CONSENT to TREAT** area to receive services at Thagard Student Health Center. **Note:** For students **under age 18**, a parent or legal guardian's signature is required on the health history form Consent to Treat (Form 1) BEFORE any treatment at Thagard Student Health Center can be given.

Student Immunization Record (Form 2)

This is a one-time requirement.

THE STUDENT IMMUNIZATION RECORD MUST be completed by AUTHORIZED PERSONNEL ONLY. To be considered official, this form and any additional records submitted to the Health Compliance Office must include: 1.)The **signature** of the authorizing person and 2.) an **office stamp** showing the complete office address, telephone and **fax number**, 3.) the student's name and date of birth and 4.) the front cover of all documents. **We reserve the right to interpret the validity of all documents submitted.**

Changes, additions, write-overs, use of different colored ink or different handwriting, or use of white-out MUST BE COMPLETELY REAUTHORIZED. All documents must be dated, signed and legible to be processed.

REQUIRED DATES MAY NOT BE ENTERED BY STUDENT OR PARENT.

Students born **BEFORE 1/1/57** should complete the Immunization Record Form and decline the meningococcal meningitis and hepatitis B vaccines at the waiver in the spaces provided, sign the form and submit it.

Students born **on or after 1/1/57** must provide proof of two MMR (measles, mumps, and rubella) immunizations. **The first MMR must have been given on or after 1/1/68 and on or after the first birthday.** The second MMR immunization must have been given 28 days or more **after** the first MMR. **Positive IgG titers** for measles (Rubeola), German measles (Rubella) and Mumps antibodies may be submitted in lieu of proof of two MMR. **Copies of the actual lab results showing the positive titers must be provided to the Health Compliance Office** before the student will be able to register for classes.

The student must sign this form at the bottom after the clinician/records custodian has completed and signed their part. Clearance for registration for classes will not be given without the **patient AND provider signature on this page.**

Patient Disclosure Authorization (Form 3)

This form must be completed and returned to the Health Center with Forms 1 & 2.

Insurance Requirements

All full time students new to Florida State University are required to provide proof of adequate health insurance coverage. **This is an annual requirement.** You must complete these requirements **before** you will be able to register for classes. Proof of health insurance can only be done on line at the student insurance web site: www.studentinsurance.fsu.edu. Purchase of the school-sponsored health insurance can also be accomplished at this site. Before completing the waiver or purchasing the school-sponsored health insurance, please review the private insurance requirements and plan information at the home page of the student insurance web site. Any changes to the purchase of the school-sponsored insurance must be requested in writing at healthcompliance@admin.fsu.edu no later than 30 days following selection of health insurance on line. For more information regarding this requirement, call our insurance broker, Collegiate Risk Management, at 850-644-4250 or 800-922-3420.



(850) 644-6230 ~ www.tshc.fsu.edu

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This information is being provided as an alternative to faxing or mailing your completed health compliance packet. Please make sure that all sections have been completed appropriately and signed. Incorrect information will cause delays in processing your information. Please allow 5 days for processing all requests.

THE FLORIDA STATE UNIVERSITY

SEARCH FLORIDA STATE

FSU Dropbox Service

You may perform the following activities:

- About the Dropbox:** What is the dropbox?
- Drop-off (upload):** Drop-off (upload) a file for a FSUID user. **Select Drop-Off**
- Pick-up (download):** Pick-up (download) a file dropped-off for you by a FSUID user.
- Login:** Use your FSUID to log in and access features not available to the public.

All files have a 10 day grace period for pickup.

If you have an FSUID, you may also login to perform additional activities:
(e.g., drop-off a file to any person, irrespective of their affiliation or email address)

Version 2.2 | UCS Dropbox Service (c) 2010

THE FLORIDA STATE UNIVERSITY

SEARCH FLORIDA STATE

Directions:

Information about the sender

This web page will allow you to drop-off (upload) one or more files for a FSUID user, downloading the file. Your IP address will be logged and sent to the recipient, as well.

- **Your Name:** Please enter the **name of the student** that you are submitting information for.
- **Your Organization:** *Please type Student Health History Form. If this is not the organization, we will NOT retrieve the form.*
- **Your Email Address:** Please provide a valid email address that we may communicate any issues we encounter.

Information about the recipient

- **Name:** Please type **Health Compliance Office**
- **Email:** Please type **healthcompliance**

Choose the file you would like to upload

Please select the health history file and in the **Description**

- **Type:** **Health History Form.**

Finally press the Drop-off the File button to submit your file.

1. Information about the Sender

Your name: (required)

Your organization:

Your email address: (required)

Send an email to me when the recipient picks-up the file(s).

2. Information about the Recipient

Recipient 1: Name:

Email: @fsu.edu

3. Choose the File(s) you would like to Upload

File 1: No file chosen

Description:

[Return to the FSU Dropbox Service main menu.](#)



REQUIRED STUDENT HEALTH HISTORY FORM

YOU WILL NOT BE CLEARED TO REGISTER AT FSU WITHOUT THIS COMPLETED FORM (ALL PAGES) ON FILE AND ADEQUATE PROOF OF IMMUNIZATIONS

MAIL or FAX ALL COMPLETED PAGES TO:
 FSU Student Health and Wellness Center
 Health Compliance Office
 109 Collegiate Loop
 TALLAHASSEE, FLORIDA 32306-2140
 Fax: 850.644.8958

TO VERIFY CLEARANCE CHECK
<https://admissions.fsu.edu/StatusCheck/>
THIS FORM REQUIRES FIVE DAYS FOR PROCESSING

Information:
 healthcenter.fsu.edu
 Insurance: 850.644.4250
 Immunizations: 850.644.3608

Or Electronically submit using FSU drop box (see attachments within packet for instructions for submitting Personal Health Information in a Secure Format)

SECTION A -

PLEASE PRINT LEGIBLY (ILLEGIBLE FORMS WILL NOT BE PROCESSED)

NAME Last	First	Mi	DOB ____/____/____	FSU SN or FSU ID	Sex F M	Race
Address		City	State	Zip		
Home Phone:()			Cell Phone:()			
Email Address:						
Primary Care Physician:		Address		Phone/Fax		

SECTION B-

Please list any relevant personal medical history: _____

Please list any relevant family medical history: _____

Do you have any allergies (to incl. medications): No Yes Please list if answered yes: _____

SECTION C -

PLEASE READ AND INITIAL EACH SECTION BELOW

Student Observers

_____ I understand and acknowledge, by signing this document, that FSU Student Health and Wellness Center, as part of Florida State University, may have students from healthcare majors (i.e. College of Nursing, College of Medicine, College of Human Sciences) as observers during the course of my visit at TSHC. I further understand that the TSHC staff members will inform me when a student is observing my care. I give TSHC permission to allow a student observer and I understand that I may at any time, decline to have a student observer during the course of my care at TSHC.

Notice of Privacy Policy

_____ I acknowledge, by my signature below that I have received a copy of the FSU Student Health and Wellness Center Notice of Privacy Practices, included in this packet as Form 4, as required by Federal Regulations.

Consent to Treat

I authorize FSU Student Health and Wellness Center, its agents (ie College of Medicine, College of Nursing, First Responder Unit) and employees, to provide and perform such care, procedures, tests, and other services as are considered advisable by my clinician for my health and well being. I acknowledge that no guarantees have been made to me as to the effect of such examinations, procedures, and treatment of any condition.

Signature _____ Date: _____

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18: I CONCUR WITH THE ABOVE AND AUTHORIZE, AT THE DISCRETION OF HEALTH CENTER PERSONNEL, MEDICAL AND SURGICAL CARE INCLUDING EXAMINATIONS, TREATMENTS, IMMUNIZATIONS AND THE LIKE FOR MY SON/DAUGHTER. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable effort will be made to contact me but the failure to make contact will not prevent emergency treatment if necessary to help preserve life or health.

Parent /Guardian Signature: _____ Date: _____



STUDENT IMMUNIZATION RECORD

YOU WILL NOT BE CLEARED TO REGISTER AT FSU UNTIL THIS COMPLETED FORM IS ON FILE AT THE HEALTH COMPLIANCE OFFICE

PART A – To be completed by Clinician or Records Custodian REQUIRED

BOTH IMMUNIZATIONS MUST BE COMBINED MMRs. SINGLE SHOTS ACCEPTED ONLY IF ADMINISTERED ON THE SAME DATE.

MMR	Dose 1 _____ / _____ / _____ Month Day Year	Dose 2 _____ / _____ / _____ Month Day Year	
Meningococcal Vaccine If not provided student must sign required waiver below.	Dose 1 _____ / _____ / _____ Month Day Year	Dose 2 _____ / _____ / _____ (if applicable) Month Day Year	
Hepatitis B If not provided student must sign required waiver below.	Dose 1 _____ / _____ / _____ Month Day Year	Dose 2 _____ / _____ / _____ Month Day Year	Dose 3 _____ / _____ / _____ Month Day Year

RECOMMENDED

Polio	_____ / _____ / _____ Month Day Year	Td (most recent booster)	_____ / _____ / _____ Month Day Year
TB skin test (PPD) Mm _____ Pos _____ Neg _____ If positive provide documentation of treatment type and dates.	_____ / _____ / _____ Month Day Year	Tdap (most recent booster)	_____ / _____ / _____ Month Day Year
Chicken Pox (varicella) Or date of disease	Dose 1 _____ / _____ / _____ Month Day Year Dose 2 _____ / _____ / _____ Month Day Year	Gardasil	Dose 1 _____ / _____ / _____ Month Day Year Dose 2 _____ / _____ / _____ Month Day Year Dose 3 _____ / _____ / _____ Month Day Year
Hepatitis A	Dose 1 _____ / _____ / _____ Month Day Year Dose 2 _____ / _____ / _____ Month Day Year	Pneumococcal Vaccine (as indicated)	_____ / _____ / _____ Month Day Year

Additional physician comments regarding any history of prior vaccine allergic reactions, medical contraindications, etc:

Physicians Signature & Date

AUTHORIZED CLINICIAN or Records Custodian SIGNATURE: My signature verifies, as of this date, all entries documented. The form must be signed by the person who entered the information.

TYPED OR PRINTED NAME AUTHORIZED SIGNATURE DATE OFFICE STAMP WITH OFFICE ADDRESS & fax #
Immunizations given after the form has been signed must be separately documented on a separate sheet of paper, including authorized signature and office stamp with office address and fax. Use of a prescription pad is sufficient.

Part B - Must Be Completed By Student

Meningococcal and Hepatitis B - Waiver must be completed if date of vaccines are not provided above.
I have received the required information regarding the risks of acquiring meningococcal meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations. I understand that declining these vaccines now does not mean I may not receive them in the future.
_____ I decline receiving the meningococcal vaccine _____ I decline receiving the hepatitis B vaccine.
Initials Initials

STUDENT SIGNATURE REQUIRED REGARDLESS OF AGE. I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS ON THIS FORM. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at Thagard Student Health Center and for my registration here or at any other university.
Printed Name: _____ FSUSN or FSUID _____ DOB _____
Signature _____ Today's Date _____



Health Center Patient Disclosure Authorization

Student Name (Printed) _____

Last First MI FSU SN Date of Birth

Information Release:

Emergency Contact Name: _____ Relationship to Patient: _____

Address: _____ Phone: (____) _____

Do you want your treatment at Thagard Student Health Center discussed with this person? Yes No

The staff of Thagard Student Health Center consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan. **This does not include Psychiatry.**

YOU MAY DISCUSS MY TREATMENT AT THE THAGARD STUDENT HEALTH CENTER WITH:

Note: Accepted relationships include immediate family members such as, mother, father, spouse, and children. The Health Center will not honor disclosure for discussion of medical conditions, test results, and/or treatment plan to departments on campus or relationships other than those stated without proper medical release forms on file.

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING

- I understand and acknowledge by signing this document that I give Thagard Student Health Center permission to file a claim to my health insurance carrier for the purpose of payment for services I have received at TSHC. I further understand and agree that TSHC may not be a contracted provider with my individual health insurance plan and that I may be responsible for any unpaid balance, or services not covered by my insurance plan. I understand that it is my responsibility to know what coverage I have under my individual plan. I give TSHC permission to place these unpaid balances on my account with Student Financial Services. I am aware that any unpaid balance on my account with Student Financial Services will generate a "hold" being placed on my registration and that I may be assessed service fees on balances not paid by the due date assigned by Student Financial Services.
- I understand I have a right to revoke this authorization at any time, except for cases where information has already been disclosed to those listed above, by signing the revocation section of this form.

Signed: _____ Date: _____

Note: The section below is to be completed only should you decide to revoke the above authorization.

Revocation:

I am requesting the revocation of this current form contained within my electronic medical record.

Name: _____

DOB: _____

Signature: _____

Date: _____

be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission occurred. You will not be retaliated against for filing any complaint.

Amendments To This Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all PHI we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy or changes in the law affecting this Privacy Notice by posting to our website notice of the revision or amendment.

On-Going Access To Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time. Send a written request to the Privacy Officer at Thagard Student Health Center, Florida State University, Tallahassee, FL 32306-2140, make a phone request at (850) 644 5523 or an electronic request on the web at www.tshc.fsu.edu. An electronic version of this Privacy Policy is also available on the website listed above.

This Notice of Privacy Policy is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires TSHC [by law] to maintain the privacy of your Protected Health Information (PHI) and to provide you with notice of TSHCs legal duties and privacy policies with respect to your PHI. We are required by law to abide by the terms of this Privacy Notice.

Information (850) 644-6230
Appointments (850) 644-4567
Main Fax (850) 644-1491
TDD (850) 644-2383

Thagard Student Health Center, Florida State University
Division of Student Affairs, Tallahassee, FL 32306-2140
Available in Alternate Format.



NOTICE OF PRIVACY POLICY

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

*Effective April 14, 2003
As Amended December 8th, 2010*



THAGARD STUDENT HEALTH CENTER

Lesley K. Sacher, MHA, FACHE, FACHA
TSHC Director

Your Protected Health Information (PHI)

Your PHI is protected by law and includes any information, oral, written or recorded, that is created or received by certain health care entities, which includes health care providers (such as hospitals and physicians), health insurance companies or health plans. The law specifically protects health information that contains data such as: name, address, social security number, and any other information that could be used to identify you as an individual patient who is associated with that particular health information.

Uses or Disclosures of Your PHI

Generally, we may not use or disclose your PHI without your permission. In addition, once your permission has been obtained, we are only allowed to disclose your PHI in accordance with the specific terms of that permission. The circumstances under which we are permitted by law to use or disclose your PHI are described below.

Without Your Consent

When using or disclosing PHI, with or without your consent, we are required to disclose the minimum amount necessary that is reasonably required to provide those services or complete those activities.

For Treatment: We may use or disclose your PHI in order to provide medical treatment to you and to coordinate or manage your health care and related services. For example, we may use and disclose your PHI to other health care providers when you need a prescription, lab tests, x-rays or other health care services.

We may use or disclose PHI to another provider for treatment such as when referring you to a specialist.

For Payment: We may use or disclose your PHI in order to bill and receive payment for services. For example, a bill may be sent to your insurance company which includes medical information. We may also notify your health plan about a treatment you are expected to receive in order to receive prior approval.

We may use or disclose information to consumer reporting agencies relating to the collection of premiums or reimbursements.

For Health Care Operations: This is necessary to ensure all patients receive quality care. For example, medical staff may use the information for training and staff evaluation purposes and to assess the treatment outcomes.

We may disclose your PHI to our business associates to carry out treatment, payment or health care operations. We employ business associates to perform certain jobs such as diagnostic testing and evaluation and billing. We disclose the minimum amount of information necessary for our business associates to perform the services for which they were hired. Our business associates are legally required to follow the same privacy laws that we follow.

We may contact you to provide appointment reminders or

information about treatment alternatives or other health related benefits and services that may be of interest to you.

Unless we receive an objection from you, we may use or disclose your PHI in the following ways:

We may use or disclose information to notify or assist in notifying a family member, legal representative, or another person responsible for your care.

We may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share medical information about you if necessary for emergency circumstances.

We may use or disclose your PHI to a regional health information organization (RHIO). We are a participant in the Big Bend RHIO and, as such, share certain patient information with other participants. Should you require treatment at another participating facility, that provider may gather health information through this system in order to provide treatment.

As Required By Law: We may use or disclose your PHI to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law such as: public health activities, reporting to social services in the case of abuse, neglect or domestic violence, health oversight activities (audits, civil, criminal or judicial investigations), law enforcement activities, military and veterans activities, matters of national security and to avert a serious threat to health or safety.

Other Uses With Your Specific Authorization

Except as otherwise permitted or required, we may not use or disclose your PHI without your written authorization. Further, we are only allowed to use or disclose your PHI in accordance with the terms of such authorization. You may revoke your authorization to use or disclose PHI at

any time, with the exception of: a) actions already taken in reliance on such authorization, or, b) if you provided the authorization as a condition of obtaining health insurance coverage, in which case other laws are in effect that provide the insurer with the right to contest a claim under the policy.

Your PHI Rights

Under HIPAA, you have certain rights with respect to your PHI. The following is a brief overview of those rights and our duties as health professionals to enforce those rights.

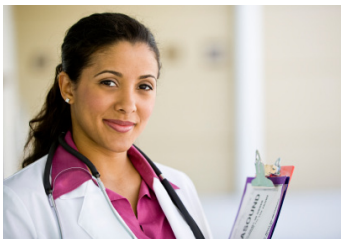
Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. You may request restrictions in writing to our Privacy Officer on the following uses or disclosures: a) to carry out treatment, payment or health care operations; b) disclosures to family members, relatives or close personal friends of PHI directly relevant to your care, or payment related to your health care, or your location, general condition or death; c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; d) permitting others to act on your behalf to pick up filled prescriptions, medical supplies, X-rays or other similar forms of PHI; or e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a particular restriction we are bound not to use or disclose your PHI in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your PHI. We require a written request. In addition, we may condition the provision of confidential communications on you providing us with information as to how



payment will be handled and specification of an alternative address or other means of contacting you. We may require that a request contain a specific statement that disclosure of all or part of the information to which the request pertains could endanger you. We cannot require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from us by alternative means or at alternative locations.

Right To Inspect & Copy Your PHI

Your designated record set is a group of records we maintain that includes: medical records and billing records about you; enrollment and payment records; claims adjudication, and case or medical management records systems. You have the right of access in order to inspect and obtain a copy of your PHI contained in your designated record set, except for: a) psychotherapy notes, b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your PHI in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or similar form or format. We may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your PHI or mailing a copy to you at your request. We will discuss the scope, format and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your PHI or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage (if you request a mailing), and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain PHI as permitted or required by law. To the extent possible, we will attempt to accommodate any reasonable request for PHI by giving you access to other PHI after excluding the information which we have grounds to deny

access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your PHI

You have the right to request that we amend your PHI or a record about you contained in your designated record set for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, b) the information is not part of your designated record set maintained by us, c) the information is prohibited from inspection by law, or d) the information is accurate and complete. We require that you submit a written request and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services (DHHS). This denial will also include a notice that if you do not submit a statement of disagreement you may request that we include your



request for amendment and denial with any future disclosures of your PHI that are the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by

you as having received your PHI prior to amendment and persons that we know have the PHI that is the subject of the amendment and that may have relied or could foreseeably rely on such information to your detriment. All requests for amendment shall be sent to:

Attn: Privacy Officer, Thagard Student Health Center, Florida State University, Tallahassee, FL, 32306-2140.

Right To Receive Your PHI Accounting Of Disclosures

You have the right to receive a written accounting of all disclosures of your PHI that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure, or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: a) treatment, payment and health care operations, b) disclosures pursuant to your authorization, c) disclosures to you, d) or to persons involved in your care, e) for national security or intelligence purposes, f) to correctional institutions. We will provide the first accounting to you in any twelve (12) month period without charge but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to:

Attn: Privacy Officer, Thagard Student Health Center, Florida State University, Tallahassee, FL 32306-2140

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may file your complaint with DHHS at the Office for Civil Rights, DHHS, 61 Forsyth St. SW. - Suite 3B70, Atlanta, GA 30303-8909, (404) 562-7886. You may submit your complaint in writing by mail to our privacy officer at Thagard Student Health Center, Florida State University, Tallahassee, FL 32306-2140, (850) 644-5523 or e-mail using our e-comment card at www.tshc.fsu.edu. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to

Vaccine Information - PLEASE READ

Many other extremely valuable vaccines are available that are not required but highly recommended to optimize a lifelong, preventive healthcare program.

Bacterial Meningitis

Young adults between the ages of 17-24 are at increased risk of developing a severe form of bacterial meningitis called meningococcal meningitis. The American College Health Association and the Centers for Disease Control (CDC) recommend that students consider getting the meningitis vaccine. This bacterial infection, although rare, may cause severe neurologic impairment, partial loss of limbs, or death (9-12% mortality rate). Living in residence halls, bar patronage, and exposure to alcohol and cigarette smoke further increase the risk of infection within this age group. The incidence in young adults is about one case per 100,000. For freshmen living in residence halls, it is 3.8 or more per 100,000.

The meningococcal bacterium involved with invasive disease, such as meningitis or sepsis (a bloodstream infection) is usually one of the five different subtypes, called Serogroups A, B, C, Y, and W-135. The current vaccine does not stimulate protective antibodies to Serogroup B, but does against the remaining four types. In the past, Serogroup B caused about 50% of the disease burden in the U.S. but more recently, it has decreased to about 27% or less, making vaccination more protective against the other serogroups that have proportionately increased. The vaccine is safe and is estimated to protect for 3-5 years. For those who received a dose of vaccine at age 15 or younger, a 2nd booster has been recommended. Those who received a dose at age 16 or older do not need a booster dose.

Hepatitis B

Hepatitis B is a serious viral liver infection, prevalent worldwide, which can lead to chronic liver disease and liver cancer. The State of Florida has requirement for all school-age children to complete the three-shot series, but older students or out-of-state students may not be familiar with this recommendation. The Hepatitis B vaccine is extremely safe, effective and is required for any individual who may possibly be exposed to blood or other body fluids in their line of work or through sexual contact. We highly recommend you consider getting this vaccine or at least discussing it with your primary care physician.

Polio, Tetanus, Tuberculosis

Have your doctor review the status of your Polio and Tetanus immunizations. Tetanus is recommended every 10 years routinely or within five years for contaminated or deep puncture wound. It is usually given as a tetanus/diphtheria combination shot called Td but a one-time dose of Tdap (which includes a small booster dose of pertussis) may be given anytime beyond 2 years or more from a previous Td, especially if exposure to children or working in health care is ongoing. Following this onetime Tdap, Td boosters should resume the 10 year schedule.

A skin test for tuberculosis called a PPD should also be considered at this time if your doctor determines you have been potentially exposed, such as working in a high risk clinic or institution, extended travel to at risk countries, etc.

Chicken Pox (Varicella)

Chicken Pox (Varicella) is not uncommon among college students who have not yet experienced this childhood ill-ness. Varicella vaccination is available and is highly recommended for all children, adolescents, and young adults who are susceptible to this viral disease. It is given as a two-shot series, one to two months apart. The vaccine is generally well tolerated; 3-5% may experience a mild, varicella-like rash or low-grade fever, but complications are rare.

Hepatitis A

Hepatitis A, another viral illness affecting the liver, is especially prevalent in developing countries and is most often transmitted via contaminated food and water. Outbreaks occur throughout the United States and will likely continue and possibly increase in the next decade. Though not a cause of chronic liver disease, adults who develop Hepatitis A can be extremely ill and lose significant school or work time during the course of an infection. The Hepatitis A vaccine is very safe and is given as a two-shot series, six months apart. It is essential for anyone planning to travel to developing countries, but may be a good investment in your health even in the U.S.

Vaccine Information - PLEASE READ

Many other extremely valuable vaccines are available that are not required but highly recommended to optimize a lifelong, preventive healthcare

Influenza

Yearly flu shots (early October to mid December) are recommended for everyone, but are especially indicated for anyone with asthma, chronic heart or lung disease, diabetes, or other health problems that compromise the ability to fight infections. The Thagard Student Health Centers provides influenza vaccines, often free to students as budget permits, but supplies are limited.

Pneumococcal Vaccine

The pneumococcal vaccine, often misquoted as the "pneumonia vaccine," is recommended for students at risk for serious pneumococcal infections (those with asthma, diabetes, chronic heart or lung disease, weakened immune systems, etc.) This vaccine reduces the incidence of the most common cause of community acquired bacterial pneumonia, called pneumococcal pneumonia. Check with your family physician to see if you are a candidate.

HPV Vaccine

Currently 2 vaccines against Human Papilloma Virus are available which can protect against the development of cervical cancer and some types of venereal warts, HPV4 (Gardasil) and HPV2 (Cervarix). Highly recommended for females before they become sexually active, one of the vaccines, Gardasil, is also now approved for males as well. Most often given between ages 9 to 12, many patients, especially males, may wish to initiate this vaccine or complete the series before coming to FSU or after they arrive.