With my consent, the UNT Student Health & Wellness Center (SHWC) may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to the UNT SWHC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been provided with a copy of SHWC’s Notice of Privacy Practices that provides information about how SHWC uses and discloses PHI about me, prior to signing this consent. UNT SHWC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to UNT SHWC Privacy Officer at P.O. Box 305160, Denton, TX 76203-5160.

With my consent, the UNT SHWC may call my home or other designated location and leave a message on voice mail in reference to any items that assist the SHWC in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the UNT SHWC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements.

I have the right to request the UNT SHWC restrict how it uses and discloses my PHI to carry out TPO. However, the SHWC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the UNT SHWC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the SHWC has already made disclosures in reliance upon my prior consent.

_________ ___________________________ __________________________________
Printed  Patient's Name                                                                 Date

_________________________ ___________________________ __________________________________
Signature  of Patient  (If 18 years of age or older)                      Date

_________________________ ___________________________ __________________________________
Printed  Name of Parent of Legal Guardian  
(If patient is under 18 years of age)                      Relationship to Patient

_________________________ ___________________________ __________________________________
Signature  of Parent or legal Guardian  
(If patient is under 18 years of age)                      Date

(NPP Policy)