Campus Health
TULANE UNIVERSITY

CONSENT TO THE VERBAL INTRA-UNIVERSITY SHARING OF CONFIDENTIAL HEALTH INFORMATION

It is the policy of Tulane University Campus Health ("TUCH") to share information within Tulane University, to include sharing by verbal discussion, to facilitate the delivery of essential campus resources and support services. In order to share this information at the direction of a student, TUCH requires a signed consent form. Please be aware that disclosure of Confidential Health Information without a student's consent is allowed but under only very limited exceptions. Tulane University, to include TUCH leadership, believes that these exceptions should be construed in a balanced manner protecting student health, safety, and privacy interests. TUCH Staff and Tulane University Officials will always take care to consider the impact of such sharing, and will only disclose the minimum amount of Confidential Health Information necessary for the intended purpose. Tulane University gives great weight to the reasonable expectations of students that their Confidential Health Information generally will not be shared, or will be shared only in the rarest of circumstances, and only to further important purposes, such as assuring campus and student safety. This form must be fully and completely filled out to be valid.

I, the patient listed below, hereby authorize The Administrators of the Tulane Educational Fund d/b/a Tulane University and Tulane University Campus Health to share my Confidential Health Information through verbal communication with office(s) designated below.

PATIENT INFORMATION

Name: _____

DOB (MM-DD-YYYY): _____ Splash ID: _____

Phone: _____

PURPOSE OF DISCLOSURE

☐ Coordination of Care
☐ Academic
☐ Case Management

SPECIFIC TREATMENT DATE(S)

☐ Single treatment date of (MM/DD/YR)_____.
☐ Period from (MM/DD/YY)_____ to (MM/DD/YY) _____.
☐ Any and all treatment encounters to date.

AUTHORIZED DURATION OF COMMUNICATION

☐ Single date of (MM/DD/YR)_____.
☐ Period from (MM/DD/YR)_____ to (MM/DD/YR)_____.
☐ Current academic year, July 1 to June 30

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Specific description of information to be used or disclosed. (*Check only those that apply and describe below.)*

☐ Attendance
☐ Diagnosis
☐ Treatment recommendations
☐ Prognosis
☐ Medications
☐ Safety

Description:

SHARE WITH RECIPIENT OFFICE

☐ Student Resources and Support Services
☐ Case Management and Victim Support Services (CMVSS)
☐ Campus Health
☐ Health Center for Student Care
☐ CAPS for Counseling Services
☐ The Well for Health Promotion
☐ Tulane Emergency Medical Services
☐ Department of Athletics
☐ Dining Services
☐ Housing and Residence Life
☐ ROTC
☐ Title IX
☐ Other: _____

PATIENT SIGNATURE

I have read the above and authorize the disclosure of the verbal Confidential Health Information as stated.

Signature of Patient: _____ Date: _____

TREATMENT PROVIDER and DEPARTMENT

Name: _____

☐ Health Center ☐ CAPS ☐ The Well