SUNY Potsdam Watkins Student Health Services

PATIENT RIGHTS AND RESPONSIBILITIES

**PATIENT RIGHTS:**

1. To receive treatment with respect, dignity, and consideration.

2. To be given privacy and to expect confidential treatment of medical records, except for disclosures which are required by law.

3. To complete information concerning your diagnosis, evaluation, treatment, and prognosis.

4. To receive the necessary information to participate in decisions about your care and to give, or refuse, your informed consent before any diagnostic or therapeutic procedure is performed.

5. To make appointments whenever possible.

6. To receive reasonable continuity of care and to know the names, credentials and titles of those providing your care, and to change your primary care provider if desired.

7. To refuse to participate in any experimental research projects.

**PATIENT RESPONSIBILITIES:**

1. To provide accurate information about your medical history, medications, over-the-counter medications, dietary supplements, allergies, and medication sensitivities.

2. To have a complete medical record on file at Student Health Services, including immunization records.

3. To be immunized against measles, mumps, and rubella.

4. To ask questions if you do not understand any portion of your diagnosis, evaluation, treatment, prognosis, or instructions for care.

5. To make appointments whenever possible.

6. To accept financial responsibility for any fees not covered by your insurance.

7. To be respectful to the medical providers, the staff, and the other students at Student Health Services.

8. To follow the treatment plan prescribed by your provider.

9. To inform your provider about any living will, medical power of attorney, or other directive that could affect your health care.

**ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how certain health information about me may be used and disclosed by health care facilities and operations of the State University of New York, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and generic information.

______________________________________  ______________________________________
Signature of Patient or Personal Representative  Date

______________________________________  ______________________________________
Print Name of Patient or Personal Representative  Description of Personal Representative’s Authority

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