Eric Cohen Student Health Center of USC
Keck Medicine of USC

February 03, 2017

Dear USC Visiting Student,

I would like to extend a warm welcome to the USC Health Science Campus. The Eric Cohen Student Health Center of USC (ECSHC) will process your health clearance paperwork to help you gain compliance for your clerkship. We will begin your health clearance process for your clerkship at USC once you've completed steps 1-4 below.

1. **Click here to fill out the AAMC Immunization form.**
   - For the tuberculosis screening section, you **must fill out Section A** and it must include **either** 2 (two) TSTs both within one year of your clerkship start date with USC **OR** an IGRA blood test within one year of your clerkship start date with USC. **Your most recent TST or your IGRA blood test cannot expire during your clerkship with USC.**

2. **Fill out the highlighted areas of the attached LA County Employee Health Services E2 form.**

3. **Read and sign the attached USC Notice of Privacy Practices.**

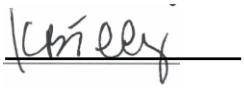
4. **Upload to VSAS:**
   - ☐ Your completed AAMC immunization form
   - ☐ LA County Employee Health Services E2 form with the highlighted areas filled out
   - ☐ A signed copy of the USC Notice of Privacy Practices

If you have any questions, please contact the health clearance line at 323-442-5980 or contact the visiting students' coordinators Roxie Solano or Bobby Cong by email at rsolano@usc.edu or bcong@med.usc.edu with subject title "Visiting Student".

If you would like to complete your health clearance requirements (i.e. blood tests, TB tests, etc.) at our health center, please visit http://ecohenshc.usc.edu/health-clearance/prices/ .

Although our time with you will be short, we hope to be of service to you.

Fight On!



Kimberly Tilley, MD
ECSHC Medical Director
Eric Cohen Student Health Center
Keck Medical Center of USC
University of Southern California
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E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

☞ See GENERAL INSTRUCTIONS on last page.

FOR NON-DHS/NON-COUNTY WFM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C#:
E-MAIL ADDRESS:	HOME/CELL PHONE #:	DHS FACILITY:	DEPT/WORK AREA/UNIT:
JOB CLASSIFICATION:	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:	AGENCY CONTACT PERSON:	AGENCY PHONE #:

In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 8 & 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases prior to assignment. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services to verify.

SECTION 1: FOR WORKFORCE MEMBER TO COMPLETE

TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes

☐ No ☐ Yes Cough lasting more than 3 weeks	☐ No ☐ Yes Excessive fatigue/malaise
☐ No ☐ Yes Coughing up blood	☐ No ☐ Yes Recent unprotected close contact with a person with TB
☐ No ☐ Yes Unexplained/unintended weight loss (> 5 LBS)	
☐ No ☐ Yes Night sweats (not related to menopause)	☐ No ☐ Yes A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
☐ No ☐ Yes Fever/chills	
☐ No ☐ Yes Excessive sputum	

If you have any of the above symptoms, you should meet with your provider to determine whether a chest x-ray is indicated.

SECTION 2: FOR HEALTHCARE PROVIDER TO COMPLETE OR MUST PROVIDE SOURCE DOCUMENTS

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal
Must have 2 negative TST < 12 months of start date.

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS (Indicate: Reactor / Non-Reactor / Converter)
	1st								mm	
	2nd								mm	

If either result is positive, send for CXR and complete Section C below.

OR

B

Negative IGRA: Quantirferon or Tspot(<12 months)	Date:	Results	☐ LA County ☐ Outside Document	STATUS

If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C

Positive TST (no date requirement)	Date:	Results mm	☐ LA County ☐ Outside Document	STATUS
CXR (at or after date of +TST)	Date:	Results _____	☐ LA County ☐ Outside Document	

OR

CONTINUE ON NEXT PAGE

E2

CONFIDENTIAL

PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#

D	Positive IGRA: Quantirferon or Tspot (no date requirement)	Date:	Results _____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (at or after date of +IGRA)	Date:	Results _____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	months with ____	☐ Outside Document	**STATUS**
	CXR (after date of completed Tx)	Date:	Results _____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_months with ___	☐ Outside Document	**STATUS**
	CXR (at or after date of Tx)	Date:	Results _____	☐ Outside Document	

AND

G

IMMUNIZATION DOCUMENTATION HISTORY (MANDATORY)

	Titer Result Date	Titer Result	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine Received	Declined Vaccination (may be restricted from hospital/patient care)	
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 1**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation

AND

H

Vaccination	Date Received	Date of Declination Signed	
Tetanus-diphtheria (Td) every 10 years		**OR**	
Acellular Pertussis (Tdap) X 1			

AND

CONTINUE ON NEXT PAGE

E2

CONFIDENTIAL

PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#

	Vaccination (MANDATORY to offer to WFM who have potential to be exposed to blood or body fluid)			If not reactive, vaccinate with HepB series (3 doses)	Date Received	Vaccine		☐ N/A (job duty does not involve blood or body fluid)
I	Hepatitis B Surface Ab Titer (HbsAb) anti-HBs	Titer Result Date	Titer	**AND/OR**			**OR**	**Date** _____ ☐ Declination signed
			☐ Reactive ☐ Non-reactive					**Date** _____ **HbcAb/** ☐ Non-reactive **anti-HBc** ☐ Reactive
								Date _____ **HbsAg** ☐ Non-reactive ☐ Reactive

AND

	Vaccination	Date Received	Facility Received		Date Declination Signed
J	Seasonal Influenza (one dose for current season)			**OR**	**Note:** Must wear mask during influenza season.

AND

K	Respiratory Fit Test (Complete Form N-NC)	Date:	☐ **Pass** ☐ **Fail** ☐ **Powered Air Purifying Respirator** ☐ **N/A** (Job duty does not involve airborne precautions)
L	Color Vision (MANDATORY for WFM working with point of care testing or electrical)	Date:	☐ **Pass** ☐ **Fail** ☐ **N/A** (Job duty does not involve POC testing or electrical)

FOR HEALTHCARE PROVIDER:

☐ I attest that all dates and immunizations listed above are correct and accurate.

Date:	Physician or Licensed Healthcare Professional Signature:	Print Name:
Facility Name/Address:		Phone #:

OR

FOR WORKFORCE MEMBER:

☐ Required source documents attached.

Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY

☐ WFM completed pre-placement health evaluation.		Date of clearance:
Signature:	Print Name:	Today's Date:

CONTINUE ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#

SECTION	GENERAL INSTRUCTIONS FOR EACH SECTION
TUBERCULOSIS DOCUMENTATION HISTORY **ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**	
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
B	WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (IGRA). If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually. a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work. If IGRA is positive, record results and continue to Section D.
TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**	
C	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.
D	If IGRA is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR at or after first positive IGRA will be accepted for clearance to work as long as TB symptom screening is negative.
E	If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after active TB treatment will be accepted for clearance to work as long as TB symptom screening is negative.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.
IMMUNIZATION DOCUMENTATION HISTORY Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.	
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine varies depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.**
H	**<u>Td</u>** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **<u>Tdap</u>** should replace a one time dose of Td for HCP aged 11 and up.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B virus, HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

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

What is this Notice and Why Is It Important?

By law, the University of Southern California (USC)[1] must protect the privacy of your identifiable medical and other health information ("health information").

USC also is required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. USC must follow the terms of this notice when using or disclosing your health information.

This notice is effective as of January 1, 2016.

How USC May Use Your Health Information

As a general rule, you must give written permission before USC can use or release your health information. There are certain situations where USC is not required to obtain your permission. This section explains those situations where USC may use or disclose your health information without your permission.

Except with respect to Highly Confidential Information (described below), USC is permitted to use your health information for the following purposes:

- **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
  - treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
  - contact you to provide appointment reminders, or
  - give you information about treatment options or other health related benefits and services that may interest you.

- **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
  - submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payor), or
  - verify that your payor will pay for your health care.

  However, we will comply with your request not to disclose health information to your health plan if the information relates solely to a healthcare item or service for which we have been paid out of pocket in full.

- **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also include uses and disclosures to:

[1] For purposes of the HIPAA Privacy Rule, USC includes those entities that comprise Keck Medicine of USC, including but not limited to, USC Norris Cancer Hospital, Keck Hospital of USC, USC's employed physicians, nurses and other clinical personnel, those units of USC that provide clinical services within the Keck School of Medicine, School of Pharmacy, the Herman Ostrow School of Dentistry, Physical and Occupational Therapy as well as USC Care Medical Group, affiliated medical foundations of Keck and their physicians, nurses and clinical personnel, USC Verdugo Hills Hospital, its nurses and other clinical personnel, Verdugo Radiology Medical Group, Verdugo Hills Anesthesia, and Chandnish K. Ahluwalia, M.D., Inc. and those units that support clinical and clinical research functions, including the Offices of the General Counsel, Audit and Compliance.

- evaluate the quality and competence of our health care providers, nurses and other health care workers,
- to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
- train students, residents and fellows, or
- identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).

In addition, USC may use and disclose your health information under the following circumstances:

- **Organized Health Care Arrangement.** USC participates in organized health care arrangements (OHCA) with other providers, including but not limited to, Childrens Hospital Los Angeles and Los Angeles County+USC Medical Center (LAC+USC). USC may share information with its OHCA members for treatment, payment and joint health care operations.

- **Directory:** USC may include your name, location in its hospitals, general health condition and religious affiliation in a patient directory without obtaining your authorization unless you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy; provided, however, that your religious affiliation will only be disclosed to members of the clergy.

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your USC health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

- **Public Health Activities:** We may disclose your health information for the following public health activities:
  - To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
  - To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
  - To report information to the U.S. Food and Drug Administration (FDA) about products and services under its jurisdiction;
  - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
  - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as

required by law to a social services or other governmental agency authorized by law to receive such reports.

- **Health Oversight Activities:** We may disclose your health information to a health oversight agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

- **Specialized Government Functions:** We may use and disclose your health information to units of the government with special functions, such as the U.S. military, under certain circumstances required by law.

- **Law Enforcement Officials, Judicial and Administrative Proceedings**: We may disclose health information to police or other law enforcement officials. We also may disclose health information in judicial or administrative proceedings, such as in response to a subpoena.

- **Coroners or Medical Examiners:** We may disclose health information to a coroner or a medical examiner as required by law.

- **Organ and Tissue Donation:** We may disclose health information to organizations that assist with organ, eye or tissue donation, banking or transplant.

- **Health or Safety:** We may disclose health information to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Research:** We may disclose health information without your authorization for certain research purposes. For example, we may disclose your information to researchers preparing a research protocol or if our Institutional Review Board committee (which is charged with ensuring the protection of human subjects in research) determines that an authorization is not necessary if certain criteria are met. We also may provide health information about you (not including your name, address, or other direct identifiers) for research, public health or health care operations, but only if the recipient of such information signs an agreement to protect the information and not use it to identify you.

- **Development Activities:** We may contact you to request a contribution to support important USC activities. For fundraising, we may disclose to our fundraising staff demographic information about you (for example, your name, address and phone number), dates on which we provided health care to you, information about the department of service or treating physician, outcome information or health insurance status without your written permission. We also may share such information about you with closely related foundations that assist us in our development activities. We will provide you an opportunity to opt-out of receiving fundraising communications. We will not disclose your diagnosis or treatment, however, unless we have your written authorization to do so.

- **Marketing Activities:** We may conduct the following activities without obtaining your authorization:
    - Provide you with marketing materials in a face-to-face encounter;
    - Give you a promotional gift of nominal value;
    - Provide refill reminders or otherwise communicate about a drug or biologic that is currently prescribed to you, so long as any payments we receive for making the communication are reasonably related to our costs;
    - Tell you about USC's own health care products and services

If we accept payments from other organizations or individuals in exchange for telling you about their health care products or services, we will ask for your authorization, except as described above or unless the communications are permitted by law without your permission. We will ask your permission to use your health information for any other marketing activities. Also, from time to time, USC receives letters from patients, their family members and friends describing the experience and care they received at USC. Where possible, we share these letters with our USC employees and patients. Prior to sharing your letter, we will remove your name and other identifying information from the letter to protect your privacy.

- **Workers' Compensation:** We may disclose health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs or as required under laws relating to workplace injury and illness.

- **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information

Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Sale of Health Information

We will not make any disclosure that is considered a sale of your protected health information without your written authorization unless the disclosure is for a purpose permitted by law.

Your Rights Regarding Your Health Information

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of minor, certain portions of the minor's medical record may not be accessible to you under California law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that

the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to the USC Office of Compliance or to whoever is indicated on your authorization.

Right to An Accounting of Disclosures of Your Health Information: Upon written request, you may obtain a list (accounting) of certain disclosures of health information made by us. The period of your request cannot exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: You may request that we restrict the use or disclosure of your protected health information. All requests for such restrictions must be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

Right to Change Terms of this Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all health information that we hold, including any information created or received prior to issuing the new notice. If we change this notice, we will post the revised notice in our practice areas and on our website at www.usc.edu/policies. You may also obtain any revised notice by contacting the USC Office of Compliance.

Further Information; Complaints

If you would like additional information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to health information, you may contact our USC Office of Compliance. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the USC Office of Compliance will provide you with the current address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

USC Office of Compliance

You may contact the USC Office of Compliance at: 3500 Figueroa, #105, Los Angeles, CA 90089-8007, (213) 740-8258 or complian@usc.edu.

UNIVERSITY OF SOUTHERN CALIFORNIA
NOTICE OF PRIVACY PRACTICES

Please sign and date below to indicate that you have received a copy of this notice. Your signature simply acknowledges that you received a copy of this notice.

_____
Print Name (Last, First, Middle Initial)

_____
Signature

_____
Date