



Dear New Franklin Pierce Student,

On behalf of Health Services, I would like to take this opportunity to welcome you to Franklin Pierce. We are located in the lower level of Granite Hall.

The required health forms to be completed and returned can be found on the attached pages. All original forms must be submitted to Health Services by August 1st for the fall semester or January 1st for the spring semester.

The Physical Examination Form and Immunization Record (pages 5&6) needs to be completed by your healthcare provider. The physical exam and tuberculosis screening or test need to be completed prior to entrance and within the last year.

Completion of all forms will facilitate your progress through Opening Day Registration. Please make every effort to supply the requested information by the due date. (Your information packet will be flagged on the day of arrival if the health requirements have not been met.)

Please return all the Health History Forms as soon as possible. We understand the physical and immunization forms may be later due to appointments with your healthcare provider.

If you experience any problems downloading the forms, please use the methods below to contact Health Services.

Phone: 603.899.4130

Fax: 603.899.1050

E-mail: healthservices@franklinpierce.edu

We look forward to seeing you soon.

Sincerely,

A handwritten signature in cursive script that reads 'Lee Potter'.

Lee Potter, RN, BSN, BC
Director of Health Services

**HEALTH HISTORY
FRANKLIN PIERCE HEALTH SERVICES
40 University Drive, Rindge, NH 03461**

**All students are required to complete and return a Health History, Immunization Record, and Physical forms.
DUE DATE: August 1st for Fall Semester – January 1st for Spring Semester**

STUDENT TO COMPLETE PAGES 1 THROUGH 4

Name: _____ Male ___ Female ___ Date of Birth: _____
Last First Middle Month Day Year

Permanent Address: _____ Soc. Sec. # _____
Street/PO Box

_____ Birthplace (Country): _____
City ST Zip Country Country

Home Telephone: _____ (_____) _____ Citizenship: _____
Country Code if International Area Code

Student Cell Phone: (_____) _____ Email: _____

Date Entering Franklin Pierce: _____ If a transfer student, college(s) attended: _____ Dates attended: _____

EMERGENCY CONTACT: I give permission to Health Services to release information to the below named people in case of a medical emergency.

1. Name: _____

2. Name: _____

Home Phone: (_____) _____

Home Phone: (_____) _____

Business Phone: (_____) _____

Business Phone: (_____) _____

Relationship to Student: _____

Relationship to Student: _____

CONSENT FOR MEDICAL CARE

To be signed by students upon reaching their 18th birthday (if you are not 18 you must report to Health Services and sign this form when you turn 18).

In event of an EMERGENCY, I hereby give permission to Health Services and its affiliated hospital to secure for me appropriate treatment, including orders for surgery and anesthesia if necessary.

Signature: _____
 Date: _____

To be signed below by parent/guardian/ or health care proxy agent; mandatory if student is under 18.

Printed Name: _____
 Relationship: _____

Signature: _____
 Date: _____

If a Health Care Proxy is available attach to this form.

HEALTH INSURANCE INFORMATION

Contact your insurance company or benefits coordinator to determine if your plan is a qualifying health plan. **Make sure Registrar's Office fills out your Enrollment Verification for your Insurance Company.**

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Telephone #: _____

Policy ID #: _____

Group #: _____

Policy Holder & Relationship: _____

STUDENTS SHOULD CARRY A COPY OF THE INSURANCE CARD AT ALL TIMES.

I have reviewed all of the information contained in this Health Form. It is true and accurate to the best of my knowledge.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____
(Required if Student is under 18)

Office use only: Entered into computer
 Health History ___ Bill of Rights ___ Insurance Information ___ Meningitis ___ MMR#1 ___ MMR#2 ___ Tetanus ___ PPD/screen ___ Physical ___

Franklin Pierce University Health Services

Personal History

ALLERGIES	Y	N	SURGERY	Y	N	WOMEN ONLY	Y	N
Penicillin			Appendectomy			Irregular Periods		
Sulfa Drugs			Tonsillectomy			Severe Cramps		
Horse Serum			Hernia Repair			Excessive Flow		
Chicken Feathers/Eggs			Fractures/Orthopedics			Breast Lumps		
Other Drugs			Handicaps/Special Needs			Other (explain)		
Foods			Other (explain)			Medications Used:		
Wasps/Bees								
Trees/Plants								
Dust/Molds			Other (explain)					
Other (explain)								

1. Please give names and dosages of prescription drugs and herbal/sports supplements: _____
2. Name over-the counter medicines used: _____
3. Serious illness/surgery/handicaps: _____
4. Is there anything else Health Services should know about your medical history? _____

Personal History (con't)

Do you have a present or past history of:	Y	N	EXPLAIN/Referring to numbers; please explain any answers in the "yes" column.
1. Alcoholism/Drug Abuse			
2. Anemia			
3. Anxiety, frequent worry			
4. Anorexia/Bulimia			
5. Asthma			
6. Back Problems			
7. Bleeding, abnormal			
8. Blindness/Visual Impairment/Contacts/Glasses			
9. Cancer or impaired immunity			
10. Chicken Pox			
11. Chronic Constipation/Colitis/Diarrhea			
12. Convulsions/Seizure Disorder/Epilepsy			
13. Depression, frequent			
14. Diabetes			
15. Ear Trouble/Hearing Loss/Deafness			
16. Headaches/Migraines - Type			
17. Heart Problems			
18. Hepatitis - Type (_____)			
19. High Blood Pressure			
20. Kidney Disease			
21. Learning Disability			
22. Mononucleosis			
23. Pregnancy			
24. Sexually Transmitted Disease			
25. Skin Trouble			
26. Substance Abuse			
27. Thyroid Disorder			
28. Urinary Tract Infection, frequent			
29. Special Needs			
30. Do you smoke or use tobacco? Amount _____ Frequency _____			

Franklin Pierce University Health Services

Personal History (con't)

1. If you drink alcoholic beverages, how many a day or week? _____
2. Do you use street drugs, if so what type? _____
3. Exercise / Activity level: Low ____ Moderate ____ Strenuous / type of Exercise _____
4. Have you had mental health counseling? If so, when and how long? _____

MEDICAL HISTORY

You are **REQUIRED** to provide this information truthfully and accurately.

FAMILY HISTORY

FAMILY MEMBER	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS/SISTERS					
STEPBROTHERS/SISTERS					

Father's Name: _____ Phone # _____

Father's Address: _____

Mother's Name: _____ Phone # _____

Mother's Address: _____

Other: _____

Do any immediate members of your family have the following?	Y	N	Relationship	EXPLAIN/Referring to numbers; please explain any answers in the "yes" column.
1. Alcoholism/Drug Abuse				
2. Allergies				
3. Asthma				
4. Convulsions/Seizures				
5. Depression				
6. Diabetes				
7. Headaches/Migraines				
8. Heart Disease				
9. High Blood Pressure				
10. High Cholesterol				
11. Kidney Disease				
12. Learning Disabilities				
13. Lung Disease/TB				

RSA 151:21 Patients' Bill of Rights. – The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:

- I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.
- II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.
- III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
- IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
- V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.
- VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
- VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.
- VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
- IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
- X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.
- XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.
- XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.
- XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
- XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
- XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
- XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.
- XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
- XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.
- XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
- XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

Source. 1981, 453:1. 1989, 43:1. 1990, 18:1-6; 140:2, XI. 1991, 365:10. 1992, 78:1, eff. June 19, 1992. 1997, 108:6, eff. Jan. 1, 1998; 331:3-8, eff. Aug. 22, 1997. 1998, 199:2, eff. Jan. 1, 1999; 388:5, 6, eff. Nov. 25, 1998. 2001, 85:1, eff. Aug. 18, 2001.

I have read and understand the entire Bill of Rights.

Signature

Date

Signature (Parent/Legal Guardian, if under 18) Date

REQUIRED DOCUMENT
DUE AUGUST 1ST FOR FALL SEMESTER AND JAN. 1ST FOR SPRING SEMESTER.

Physical Examination (To be completed by MD / NP / PA /DO)

TO THE EXAMINER: Please complete the PHYSICAL EXAMINATION below. Please comment on all pertinent findings and be sure all information is complete. Please also complete IMMUNIZATION DOCUMENT on page 6.

Name _____ Sex: M F DATE OF BIRTH / /

Participating in an Intercollegiate Sport? YES NO If YES, please identify which sport _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Vision: Without glasses Right 20/____ Left 20/____ With glasses Right 20/____ Left 20/____

Hearing: Right Normal: Yes___ No___ Left Normal: Yes___ No___ **Hearing Aid:** Yes___ No___

Laboratory Test: HCT _____ HGB _____ Urine _____ Glucose _____ Protein _____

List all Current Medications: _____

List all Allergies to Medications, Food & Other: _____

<u>No.</u>	<u>System</u>	<u>WNL</u>	<u>Abn</u>	<u>List number and describe abnormality</u>
1.	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	Nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	Neck, thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	Chest, Breasts, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	Heart, rate/rhythm/sounds	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	Genitalia, Rectal	<input type="checkbox"/>	<input type="checkbox"/>	_____
11.	Extremities, back, spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
12.	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
13.	Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____

The applicant is in _____ excellent _____ good _____ poor health.

The following abnormalities should be noted: _____

The applicant _____ does _____ does NOT have a history of emotional, psychological or psychiatric disturbance and ___ is ___ is NOT presently under psychotherapy.

Applicant may participate in sports without a restriction _____ with the following restrictions _____

 (Print Provider Name) MD/NP/PA/DO Phone ()

Address _____ Fax ()
 (Print)

Provider Signature _____ Date of Exam _____

**DUE AUGUST 1ST FOR FALL SEMESTER AND JAN. 1ST FOR SPRING SEMESTER
IMMUNIZATION DOCUMENT**

Name: _____ Date of Birth: _____
Last First Middle

Address: _____ Social Security # _____
Street City State Zip

Required Immunizations	Date	Date	Titer / Date
1. M.M.R. (Measles, Mumps, Rubella) Two doses measles required. Dose #1 given 12-15 months or later Dose #2 given at least one month after 1 st dose Or report of positive immune titer			
2. Tetanus-Diphtheria: Required Primary Completed Series Date Booster within the last 10 years	Td	Tdap	
3. Polio: Completed series of polio immunizations Last Booster-type of vaccine OPV__ IPV/OPV__ IPV____	Yes	No	
4. Meningococcal Tetravalent (freshman living in residence halls.) Tetravalent conjugate or Tetravalent polysaccharide	Menactra		
	Menomune		

5. Tuberculosis Screening (within 1 year of acceptance to Franklin Pierce.)

a) Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____

b) Is the student a member of a high-risk group? (refer below) * Yes _____ No _____

*Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts, and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Italy, Liechtenstein, Luxemburg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemia's or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

If NO, stop here. If Yes, place Tuberculin Skin Test (Mantoux only) A history of BCG vaccination should not preclude testing a member of a high-risk group.

c) Tuberculin Skin Test <small>Record of actual mm of induration transverse diameter, if no induration, write "0"</small>	Date given:	Date Read:	Result:
d) Chest X-Ray (required if tuberculin skin test is positive)	Result: Normal _____	Result: Abnormal _____	Date of X-Ray:

<u>Strongly Recommended</u>			
1) Varicella	History of Disease/ Date	Vaccine / Date	Antibody / Date
2) Hepatitis B (three doses of vaccine or Positive Hepatitis B surface antibody.)			
a) Immunization Dates:	#1	#2	#3
b) Hepatitis B surface antibody Date:		Reactive:	

ALL NEW STUDENTS
Recommended
HEALTH RELATED ITEMS TO BRING TO FRANKLIN PIERCE WITH YOU

1. Antibiotic Cream (i.e. Neosporin, triple antibiotic cream) for cuts, etc.
2. Band-Aids varying shapes & sizes
3. Cold Medicine (antihistamine, decongestant, etc.)
4. Cough Medicine
5. Gatorade (dry mix package)
6. Hydrocortisone cream (Ex. Cortaid) for itch, rash
7. Pepto-Bismol (or other antacid for nausea, diarrhea, upset stomach)
8. Reusable cold/hot pack (can be used in both microwave oven and/or freezer)
9. Scissors
10. Thermometer (small digital readout)
11. Throat Lozenges
12. Tweezers
13. Tylenol/Ibuprofen/Advil etc
14. Heating Pad
15. Extra washcloths – you can always use a clean one!
16. **MOST IMPORTANT – An insurance card in your name.**
17. If you are on any medications we suggest purchasing a lock box in which to keep them.

These items are all highly recommended to bring at the beginning of the school year and to keep your supply replenished at all times. Health Services encourages each student to advocate for their own health and being prepared with the above list is a great start.



Notice of Privacy Practices

I. 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.

Franklin Pierce Health Services is committed to protecting the privacy of your health information. This “protected health information,” or “PHI” includes information that we’ve recorded or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care that can be used to identify you. We provide you with this notice about our privacy practices to explain how, when, and why we use and disclose your PHI.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new one. You may also request a copy of this notice from our main reception area or print one from our Web Site at www.franklinpierce.edu/pages/StudentLife/healthserv.html.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

Franklin Pierce Health Services may use and disclose health information for many different reasons. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

Franklin Pierce Health Services may use and disclose your PHI for the following reasons:

- 1. For treatment.** We may disclose your PHI to physicians, nurse practitioners, nurses, pharmacists, and other health care personnel who provide you with healthcare services or are involved in your care. For example, if you are being treated for a complicated medical condition and a nurse practitioner would like to consult a physician in order to coordinate your care.
- 2. To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.
- 3. For health care operations.** We may disclose your PHI in order to operate this health services. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our attorneys, consultants and others in order to make sure we’re complying with the laws that affect us.
- 4. Emergency treatment.** We may disclose your PHI to others without your consent in certain situations. For example, your consent isn’t required if you need emergency treatment, as long as we try to get your consent after treatment or we try to get consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think you would consent if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent.

We may use and disclose your PHI without your consent or authorization for the following reasons:

- 1. When a disclosure is required by federal, state or local law judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
- 2. For public health activities.** For example, we must report information about various diseases, to government officials in charge of collecting that information. This is particularly true of certain communicable diseases.
- 3. For health oversight activities.** For example, we will provide information to assist the government or an accreditation association when it conducts an investigation or inspection of a health care provider or organization.

4. **For research purposes.** Certain limited uses and disclosures of PHI may occur for research purposes subject to approval by the university's Institutional Review Board (IRB).
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For workers' compensation purposes.** We may provide PHI in order to comply with worker's compensation laws.
7. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

C. All Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in sections II, A and B above, we will ask for your written authorization before using or disclosing any of your PHI.

III. WHAT RIGHTS YOU HAVE REGARDING PHI

A. The Right to Request Limits on Uses and Disclosures of Your PHI.

You have the right to ask that we limit how we use and disclose you PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You

You have the right to ask that we send information to you at an alternate address (for example, sending information to your campus address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We will agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI.

In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. There may be a charge associated with copies provided. We will respond to you within 30 days after receiving your written request.

D. The Right to Get a List of the Disclosures We Have Made.

You have the right to get a list of instances in which we may have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you. This list also won't include uses and disclosures made for national security purposes or to corrections or law enforcement personnel, or before the effective date of this notice.

E. The Right to Correct or Amend Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right

to request that we correct the existing information or add the missing information. You must provide the request and

your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your

request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv)

not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written

statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our

denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your

PHI, tell you that we have done it and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail.

You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you

also have the right to request a paper copy of this notice.

IV. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE COMPLAINTS/CONCERNS ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints/concerns about our privacy practices, please contact Lee Potter, Director of Health Services, Franklin Pierce Health Services, 40 University Drive, Rindge, NH, 03461, 603-899-4132, potterl@franklinpierce.edu .

IV. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Please Note: These practices follow many of the privacy rules found in the federal Health Insurance Portability and Accountability Act of 1996 and its applicable regulations. Health Services is not a covered entity under HIPAA and, therefore, is not legally bound by this specific legislation. We have chosen to adopt many of the privacy practices advocated under HIPAA as an extension of our commitment to protect the confidentiality of your health information. These practices should not be interpreted as creating contractual rights and reserves the right to make changes in these practices at any time without prior notice.