

## Durango High School – School Based Health Center

### Student/Parental Consent for Treatment

I give my consent for \_\_\_\_\_ Student's DOB \_\_\_\_\_

to receive necessary and/or advisable health services from staff at the DHS SBHC located at the Durango High School. I understand the following services will be available:

Physical exams and immunizations★Routine lab tests, such as cultures, urinalysis and anemia screening★Care for acute illness and injury★Prescription medications such as antibiotics★Care for common adolescent physical concerns (weight, acne, menstrual problems, smoking) ★Assistance in care of certain chronic conditions such as asthma and seizure disorder★Pregnancy testing  
★Diagnosis and treatment of sexually transmitted diseases★Family planning, birth control information and abstinence counseling★Drug and alcohol prevention, education assessment and counseling★Behavioral health prevention, education, and intervention related to substance use, mental health, and behavior modification (individual, family, group)★Follow-up as requested by family doctor★Student health education★Proven mind/body relaxation techniques such as biofeedback

**Physical Consent:** I understand that my son/daughter may be seen at the SBHC only with my consent if under 18 years of age or not emancipated, and that this consent will remain in force until my son/daughter leaves his/her school, or until I revoke said consent in writing. It is my responsibility to notify the school about changes in guardianship or insurance. The only exceptions to this policy are: a student may be seen one time to discuss the need for services; services will be provided in case of any emergency; the student is participating in mandatory substance abuse treatment.

**Release of Information:** The information in my son's/daughter's medical record is confidential and will not be released to any unauthorized person or agency without written consent. In conformance with Colorado law guiding all medical facilities, my son/daughter may request that visits and health information remain confidential. For me or any other party to have access to medical records regarding such information, my child must complete a written release. In order for my child to fully benefit from the DHS SBHC:

- ◆ I authorize the DHS SBHC to disclose all or any portion of my son's/daughter's medical record except for information designated as confidential by my son or daughter, to our family doctor or primary care provider (medical home base) and other DHS SBHC staff, as necessary for care and treatment and;
- ◆ The DHS SBHC staff to examine and/or copy my son's/daughter's school records including individual education plan (IEP), attendance and other records that may assist the staff in helping my son or daughter.

**Fees and billing authorization:** Services available through the DHS SBHC are made possible through the support of a variety of grants, community health, and behavioral health agencies. No child will be refused services at the SBHC. However, some fees may be charged for mental health services, immunizations, and sports physicals. The family will receive advance information of any fees.

I authorize the DHS SBHC to disclose all or any portion of my child's medical record to any person or entity performing record keeping or billing services for the DHS SBHC and any person or entities performing billing on behalf of DHS SBHC verify my or my child's medical insurance coverage or medical care benefits by written or telephone contact with my employer.

- ◆ I will provide copies of my child's health insurance card and respond to DHS SBHC representative concerning health insurance information when they call.

Signature of parent/guardian/emancipated minor \_\_\_\_\_ Date \_\_\_\_\_  
Revised 9-08



## REGISTRO PARA CENTRO DE SALUD

*Toda la informacion es confidencial!*

Letra de molde:

**A. INFORMACION DEL PACIENTE:**

Apellido: \_\_\_\_\_ Sexo: \_\_\_\_\_ Raza: \_\_\_\_\_  
 1er Nombre & 2o Nombre: \_\_\_\_\_ Idioma: \_\_\_\_\_  
 Domicilio: \_\_\_\_\_ Seguro Social: \_\_\_\_\_  
 Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Us co'digo: \_\_\_\_\_ Mi niño asiste a la escuela: \_\_\_\_\_  
 Fecha de nacimiento (FDN): \_\_\_\_\_ Grado: \_\_\_\_\_ Maestro: \_\_\_\_\_  
 Telefono de la Casa: \_\_\_\_\_ Telefono del trabajo: \_\_\_\_\_

**B. OTRAS PERSONAS QUE VIVEN EN SU CASA**

Nombre: \_\_\_\_\_ FDN: \_\_\_\_\_ Relacion: \_\_\_\_\_  
 Nombre: \_\_\_\_\_ FDN: \_\_\_\_\_ Relacion: \_\_\_\_\_  
 Nombre: \_\_\_\_\_ FDN: \_\_\_\_\_ Relacion: \_\_\_\_\_  
 Nombre: \_\_\_\_\_ FDN: \_\_\_\_\_ Relacion: \_\_\_\_\_  
 Con quien vive el niño/a? \_\_\_\_\_ Relacion: \_\_\_\_\_

**C. HISTORIA de SALUD de su niño/a:**

 Como recibe su niño(a) asistencia con problemas medicos?  No tiene nada  Cuarto de Emergencia  Doctor/Clinica

Nombre de doctor o clinica: \_\_\_\_\_ Telefono de doctor: \_\_\_\_\_

Direccion de doctor: \_\_\_\_\_

Cuando fue el ultimo fisico completo de su niño(a)? \_\_\_\_\_ Va al dentista regularmente? \_\_\_\_\_

Nombre del dentista: \_\_\_\_\_ Telefono del dentista: \_\_\_\_\_

**D. INDIQUE EL PLAN DE ASEGURANZA DE SU NIÑO/A**
 Seguro (Aseguranza) Privada Nombre de aseguranza: \_\_\_\_\_

 Medicaid HMO: \_\_\_\_\_ PCP \_\_\_\_\_ Nombre: \_\_\_\_\_

 CACP/CRDP Rating: \_\_\_\_\_  CCHP+  Ninguno  Otro (que es) \_\_\_\_\_

**E. EN CASO DE EMERGENCIA**

Por favor denos el nombre de una persona a la cual podamos llamar si no encontramos la manera de comunicarnos con usted para darle informacion medica urgente.

Nombre: \_\_\_\_\_ Telefono: \_\_\_\_\_ Relacion a su niño/a: \_\_\_\_\_

**F. PERMISO DE AUTORIZACION Y PAGO DE SEGURO**

Autorizo que mi seguro medico pague directo a MCPN, y reconozco que soy el/la responsable financiamente por cualquier balance que no sea pagado. Tambien autorizo que MCPN le de informacion a la compañía de seguros.

 \_\_\_\_\_  
 Firma del padre

 \_\_\_\_\_  
 Fecha

**WELLNESS CENTER ENROLLMENT FORM**
*All information is strictly confidential!*

Please Print

**A. PATIENT INFORMATION:**

 Last Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_ Race: \_\_\_\_\_  
 First Name & Middle Initial: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ SSN \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ School: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**B. OTHER FAMILY MEMBERS IN HOUSEHOLD**

 Father: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Mother: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Brother/Sister: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Brother/Sister: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Who does the child live with? \_\_\_\_\_ Relationship: \_\_\_\_\_

**C. CHILDS MEDICAL HISTORY**

 What is the child's usual source of medical care?  None  Emergency Room  Doctor/Clinic

Doctors Name: \_\_\_\_\_ Doctors Phone: \_\_\_\_\_

Doctors Address: \_\_\_\_\_

When was your child's last check-up? \_\_\_\_\_ Does your child regularly see a dentist? \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

**D. HEALTH CARE INSURANCE**
 Private Insurance Name of Plan: \_\_\_\_\_ Patient Number: \_\_\_\_\_

 Medicaid HMO: \_\_\_\_\_ PCP \_\_\_\_\_ Number: \_\_\_\_\_

 CACP/CRDP Rating: \_\_\_\_\_  CCHP+  No Insurance  Other \_\_\_\_\_

**E. IN CASE OF AN EMERGENCY**

Please give us the name of one person we can call if we can not reach the child's parent.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**F. INSURANCE PAYMENT AUTHORIZATION & RELEASE**

I hereby authorize my insurance benefits to be paid directly to the above MCPN clinic, and acknowledge that I am financially responsible for unpaid balance. I also authorize MCPN to release any information to the insurance company.

 \_\_\_\_\_  
 Parent Signature

 \_\_\_\_\_  
 Date



**MCPN - Metro Community Provider Network****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.**

**I. Understanding Your Health Information**

Each time you visit our community health center, a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "medical record" or "medical chart." This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Our community health center to obtain payment for services we provide to you, such as from health plans, Medicaid, or you; and
- Our community health center to measure the quality of care provided to you.

As we have in the past, we are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as stated in this Notice.

**II. How We Will Use and Give Out Your Health Information****a. Treatment, Payment, and Health Care Operations**

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example:

- We will give your health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for you;
- We may send a bill to your health insurance plan or to you; and
- Our community health center may use your medical record to review our performance and make sure you receive quality health care.

**b. Other Uses and Disclosures Allowed or Required by Law**

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care);
- To government agencies that oversee our community health center (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);

- When we are ordered by a court or judge;
- To workers' compensation programs when your health problem is from a work-related injury;
- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);
- For research studies that meet all privacy law requirements (such as research to stop a disease);
- To avoid a serious threat to the health or safety of others;
- To contact you about new treatments or medicines that may help you;
- To business associates of the community health center that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associate agrees in writing to keep your health information confidential as required by law); and
- For any other purpose required or allowed by law.

c. **Other Uses and Disclosures Requiring Your Written Permission**

Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

### **III. Your Rights Regarding Your Health Information**

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- Request limits on uses of your health information
- Receive confidential communications of your health information
- Inspect and copy your health information
- Request a change to your health information
- Receive a record of how we have used and given out your health information
- Obtain a copy of this Notice of Privacy Practices

### **IV. Questions, Concerns, and Changes to this Notice**

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact MCPN, 3701 S. Broadway, Englewood, CO 80110, Attn: Monty Moore, HIPAA Officer, 303-761-1977.

If you believe your privacy rights have been violated, you may file a complaint with our community health center or with the Secretary of the Department of Health and Human Services. To file a complaint with our community health center, contact MCPN, 3701 S. Broadway, Englewood, CO 80110, Attn: Monty Moore, HIPAA Officer, 303-761-1977. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at our community health center and on our web site.

**MCPN - Metro Community Provider Network**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of MCPN on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Staff

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Staff



**STEIN, JEFFERSON, & ALAMEDA  
KIDS AND TEEN CLINICS, CONSENT  
FOR TREATMENT**

As the responsible parent/guardian of (print child's name) \_\_\_\_\_,

- ◆ I understand that the *Clinics* include services provided by Metro Community Provider Network (MCPN), Jefferson Center for Mental Health (JCMH) and Jefferson County Public Schools.
- ◆ I understand that the *Clinics* will make the following services available to my child:
  - ◆ Well Child Checks
  - ◆ Health Histories
  - ◆ Immunizations
  - ◆ Management of Chronic Illness
  - ◆ Diagnosis, Treatment and Follow-up of minor Illness and Injury
  - ◆ Physical Examinations
  - ◆ Health Screenings
  - ◆ Routine Lab Tests – e.g. cultures, blood, urine
  - ◆ Follow-up as requested by Family Doctor
  - ◆ Dental Screenings
  - ◆ Dental Cleanings
  - ◆ Floride treatments
  - ◆ Sealants
- ◆ I understand that the *Clinics* do not offer the following services:
  - ◆ Hospitalization
  - ◆ Emergency Care (except as required by law)
  - ◆ Treatment of Complex Medical or Psychiatric Conditions
  - ◆ Dental
- ◆ I authorize the *Clinics* to disclose all or any portion of the child's medical record to any person, or entity pertinent to his/her health care, including our family doctor of primary care provider, the school health staff, JCMH, MCPN, and other Wellness Center staff.
- ◆ I also give consent to the *Clinics* to examine the child's school records, attendance and other records that may assist the staff in helping my child/ward.
- ◆ I also give consent to release any information regarding treatment to third party payors for the purpose of billing.
- ◆ I further understand that all information in the child's medical record is confidential and will not be released to any unauthorized person or agency without written consent. This practice conforms with Colorado law.
- ◆ I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the clinic of any change in the child's guardianship.
- ◆ I also certify, by signing this form, that I am legally authorized to provide this consent.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**SCHOOL BASED HEALTH CENTER SERVICES**

I consent for my child to receive health care services provided by the State-licensed health professionals of NYPH as part of the school health program approved by the New York State Department of Health. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. Mandated school health services, including: screening for vision (including eye glasses), hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Reproductive health care services, including contraception, (birth control pills, Depo (the shot) etc, testing for pregnancy, STD screening and treatment, HIV testing, PAP smears, and referrals for abnormal results, as age appropriate.
7. Nutrition and weight counseling.
8. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
9. Dental examinations including: diagnosis, treatment, and sealants where available.
10. Referrals for service not provided at the school based health center.
11. Annual Health Questionnaire

**NEW YORK CITY DEPARTMENT OF EDUCATION'S  
FACT-SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION  
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION**

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Board of Education of the City of New York (a/k/a New York City Department of Education), either because it is required by law or by Chancellor's regulation, or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, like proof of immunization. Failure to provide this information may result in the student's being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information, and that I can change my mind at any time and revoke my authorization by writing to the School-Based Health Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the New York Presbyterian Hospital School-Based Health Center to release specific medical information of the student named on the reverse page to the Board of Education of the City of New York (a/k/a New York City Department of Education).

**I consent to the release from the School-Based Health Center to the NYC Department of Education and from the NYC Department of Education to the School-Based Health Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law and Chancellor's Regulations on confidentiality:**

**Information Required by Law or Chancellor's Regulation:**

- New Entrant Exam (Form 211S)
- Immunizations
- Vision and Hearing Screening Results
- Tuberculin Test Results

**Information to Protect Health and Safety:**

- Conditions which may require emergency medical treatment (Form 103S)
- Conditions which limit a student's daily activity (Form 103S)
- Diagnosis of certain communicable diseases (**not** including HIV infection/STI and other confidential services protected by law).
- Health Insurance Coverage

**My signature on the reverse side of this form also gives my consent to New York Presbyterian Hospital to contact other providers that have examined my child and to obtain insurance information.**

Time Period During Which Release of Information is Authorized:

From: Date that form is signed on opposite page

To: Date that student is no longer enrolled in the SBHC