SCHOOL HEALTH SERVICES CONSENT FOR TREATMENT AND AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Cristo Rey Columbus High School (CRCHS) and Nationwide Children's Hospital (NCH) are partnering together to offer School-Based Supplemental Health Services to any CRCHS student. The goal of this program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the school health services offered is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. We are NOT trying to replace your regular source of healthcare. School nursing and emergency services will still be provided as always whether you consent to participate in the program or not.

Consent for Medical Care/Treatment

________________________________ **Patient/Student Name**

________________________________ **Parent/Guardian (if Patient/Student is less than 18 years)**

________________________________ **Street Address** **City** **State** **Zip Code**

(______) ________________________ **Area Code** **Phone Number**

______-______-__________ **Student Date of Birth (Month-Day-Year)**

_____ **Grade**

Gender: ☐Male ☐Female

Choose one of the following:

☐I consent to allow NCH to perform **all** services/treatment (including medications, and tests, see list below) that may be needed to diagnose, treat, and/or care for the needs of the above-referenced patient/student.

-***OR***-

☐ I consent to allow NCH to perform **only the following** services/treatment for the above-referenced patient/student:

☐ Physical Examinations

☐ Influenza immunization

☐ Tdap immunization (required for 7th grade)

☐ Care and treatment for any injury/illness

☐ Other immunizations (age-appropriate, following the American Academy of Pediatrics immunization schedule)

☐ Substance abuse prevention counseling

☐ Mental/Behavioral health counseling

I understand that this consent will remain valid throughout the 2015-2016 school year (12 month academic year) unless revoked. I may revoke this consent for treatment at any time by submitting a written request to CRCH to have me/my child removed from services. I have received the handout, *School-Based Supplemental Health Services Information for Parents and Students,* and I understand the services available. It is my responsibility to tell CRCH and NCH about changes in insurance coverage, and to notify the school nurse with all updates or changes to my child's health condition(s), immunization records, or medications.

X____________________________ **Parent/Guardian Printed Name**

X____________________________ **Parent/Legal Guardian Signature**

________ **Date**

____________________________ **Parent/Guardian Phone**

____________________________ **Relationship to Student**

____________________________ **Student (Patient) Printed Name**

____________________________ **Student (Patient Signature)**

________ **Date**

____________________________ **Student (Patient) Phone**

Notice of Privacy Practices Acknowledgement

I have been notified that the Notice of Privacy Practices forms for NCH, are available to me at CRCHS upon my request. I know that I can also view them online at ___________________.

Authorization to Release Information

I hereby authorize CRCHS and NCH to share/release/exchange information about my/my child's physical and/or mental condition, including, but not limited to, information regarding services provided to me/my child at school to/with my/my child's doctors, or referring/referral health care provider(s); and/or to any insurance company or organization that helps pay my bill. Administered immunizations will be entered into the statewide immunization information system, *Ohio ImpactSIIS*. I understand that CRCHS is covered under the federal regulations that govern the privacy of educational records and that any personal health information disclosed under this authorization may be protected by those regulations. Re-disclosure of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal Rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987). My/my child's records are protected and can only be accessed by authorized users with restricted access. I understand that this authorization will remain valid throughout the 2015-2016 school year (12 month academic year) unless revoked. I may revoke this authorization at any time by providing written notice of my intent to revoke to CRCHS. I understand that I am not required to sign this authorization form and that the NCH will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization. The health information used and/or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. Neither NCH nor CRCHS is responsible for the use of information, in whole or in part, by third parties. This authorization is given without promise of compensation. I have received a copy of this form and I understand that I have the right to inspect or copy any health information disclosed (reasonable copying fees may apply to any copying services). This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity.

Assignment of Insurance Benefits

I assign to NCH all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for services provided to me at CRCHS or at any NCH facility.

X ______________________________ X ______________________________ ________

Parent/Guardian Printed Name **Parent/Legal Guardian Signature** **Date**

______________________________ ______________________________

Parent/Guardian Phone **Relationship to Student**

______________________________ ______________________________ ________

Student (Patient) Printed Name **Student (Patient Signature)** **Date**

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Student (Patient) Phone