HOLZER HEALTH SYSTEM SCHOOL-BASED MEDICINE CONSENT FORM

Holzer School-Based Medicine (“the Program”) provides healthcare services to any student in Athens & Gallia County. The goal of the Program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the Program’s 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. Holzer is NOT trying to replace the regular source of a family’s healthcare. School nursing and emergency services will still be provided as usual regardless whether consent to participate in the Program is given.

Consent for Medical Care/Treatment

Patient/Student Name **Parent/Guardian if Patient/Student is less than 18 years of age**

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

( ) - -
Area Code **Phone Number** **Student Date of Birth (Month-Day-Year)** **Grade**

By signing below, I consent to allow the health care providers of Holzer Health System (“HHS”) who are providing services at Gallipolis City Schools, Gallia County Local School, Buckeye Hills, Federal Hocking and Alexander (collectively “the School”) to perform **all** services/treatments (including medications and tests) that may be needed to diagnose, treat, and/or care for the needs of the above-referenced patient/student.

I understand that this consent will remain valid unless revoked in writing throughout the student’s enrollment at the School. You may revoke this consent for treatment at any time by making a written request to the School to have me/my child removed from the Program. I have received a copy of the handout entitled, *School-Based Medicine Health Services Information for Parents and Students,* and I understand the services available. I understand it is my responsibility to notify the Program about changes in insurance coverage and to notify the school office manager with all updates or changes to my/my child’s health condition(s), immunization records or medications.

Notice of Privacy Practices Acknowledgement I have been given a copy of the HHS Notice of Privacy Practices and/or notified that I may find it online at: https://www.holzer.org/patients-visitors/privacy-practices/

Authorization to Release Information I hereby authorize HHS and the School 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 for treatment purposes, care coordination and/or educational purposes. HHS may also request access to my child’s academic, attendance and behavior records for the current, prior and future school years so that they can provide better services to me/my child and understand the impact of the Program. I understand this information will be kept confidential. I also hereby authorize HHS to share/release/exchange all such information with my/my child’s doctors, referring doctors, or referring/referral health care providers; and/or to any insurance company or organization that helps pay my bill. HHS may also give information to any organization to which I have applied or may apply for aid. Administered immunizations will be entered into the statewide immunization information system, *Ohio ImpactSIIS*. I understand that the School 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 my child’s enrollment at the School, unless I revoke this authorization. I understand I may revoke this authorization at any time by providing written notice of my intent to revoke to the School and/or HHS. 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 HHS nor the School 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 authorization 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 HHS, 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 through the Program.

X **X** **X** **X**
Parent/Guardian *Printed Name* **Parent/Legal Guardian *Signature*** (if student is less than 18 years) **Date/Time** **Phone**

Relationship to Student

Student (Patient) *Printed Name* **Student (Patient) *Signature*** (if 18 years or older) **Date/Time** **Phone**