# LIFQHC School Based Health Center Parental Consent Form

☐ Roosevelt High School SBHC ☐ Freeport High School SBHC ☐ Westbury High School SBHC

***Please know that your child can use the School-Based Health Center and see your other doctors. Signing this consent <u>does not</u> change your insurance, <u>does not</u> change your private doctor, and <u>does not</u> affect the number of times your child can see their private doctor.***

## STUDENT INFORMATION

**Student First Name:** _____

**Student Last Name:** _____

**Date of Birth:** _____/_____/_____ **Grade:** _____

**Sex:** Male Female

**Student Address:**_____

_____

***City*** ***State*** ***Zip Code***

**Student Cell Phone:** _____

**Student Email:**_____

***Student Social Security Number:**_____-_____-_____

***(* optional field: Used for insurance purposes only*)**

**Ethnicity:** ☐ Hispanic Black ☐ White
☐ American Indian Asian/Pacific Islander
☐ Other _____

**List the student's primary care provider, if they have one**

**Name:**_____

**Telephone:**_____

**Address:**_____

**I HERBY DESIGNATE SBHC/LIFQHC AS MY PRIMARY CARE PROVIDER** ☐ Yes ☐ No

## PARENT/ GUARDIAN INFORMATION

**Last Name**:_____ **First Name**:_____
Date of Birth: _____/_____/_____
Home/Work Tel:_____
Cell Phone: _____
Email:_____

**Last Name**:_____ **First Name**:_____
Date of Birth: _____/_____/_____
Home/Work Tel:_____
Cell Phone: _____
Email:_____

**If legal guardian, relationship to the student:**
☐ Grandparent ☐ Aunt/Uncle ☐ Foster Parent
☐ Other: _____

**Preferred Language of Parent/ Guardian**:_____

## ADDITIONAL EMERGENCY CONTACT

Name:_____
Relationship to Student:_____
Phone Number:_____

## PHARMACY INFORMATION

Indicate the Pharmacy where we can send prescriptions.
Pharmacy: _____
Pharmacy Address:_____
Pharmacy Tel:_____

## INSURANCE INFORMATION

*The School-Based Health Center provides care to students whether or not they have insurance. If the student has Medicaid, or other insurance, it is important to inform the School-Based Health Center in order to bill for the services. There is no out of pocket cost to you for the services provided by the School Based Health Center.*

**Does your child have other health insurance?**

**Yes**, Health Plan Name: _____Member ID / Policy Number: _____

**Does your child have Medicaid?** ☐ **Yes,** Medicaid ID#: _____

☐ **No,** My Child does not have Health Insurance.

Every child in New York can get health insurance, even if they are undocumented immigrants. If your child is not insured, the School-Based Health Center can connect you with a Public Health Insurance enroller.

**If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance?** ☐ Yes ☐ No

## BOX 1: PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES — Please read Box 1

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the **<u>School-Based Health Center of LIFQHC</u>**. **I grant permission for my child to enroll in the School Based Health Center in the High School. I understand consent form will remain in effect as long as my child is enrolled at the High School**, unless I notify the Health Center in writing**. I understand that I may revoke my consent at any time.**

**X**_____ _____

**Signature of Parent/Guardian** **Date**

## SCHOOL BASED HEALTH CENTER SERVICES — Box 1

I hereby give my consent for my son/daughter (indicated above) to receive "no-cost" health care provided by the physician, nurse practitioner and other State-Licensed Health professional of the LIFQHC School-Based Health Program and low cost care at the LIFQHC School-Based Health Center, to include the following comprehensive health services as part of a school health program sponsored by New York State Department of Health.

- Complete physical checkups and lab tests, including sports physical
- Hearing, Vision, Scoliosis and blood pressure screening
- Immunizations and First Aid services
- Prescription and treatment for illnesses
- Verification of pregnancy
- Dental referrals
- Testing and treatment for sexually transmitted diseases
- Health education, Nutrition and weight problems
- Counseling for school and personal problems
- Provision of health services at any of the Health Centers after school and during school vacations

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. I understand that confidentiality between the student and the medical team will be ensured in specific service area and will not be discussed with the parent or guardian unless the student agrees. The Staff of LIFQHC School-Based Health Center considers parental involvement important. The staff will encourage the student to involve his/her parent/guardian in counseling and medical services.

## Patient Acknowledgement of Receipt of Notice of Privacy Practices — Box 2

### PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

**Acknowledgement of Receipt of Notice of Privacy Practices:** I acknowledge that I have been provided a copy of the Long Island FQHC, Inc. (LIFQHC) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by LIFQHC and how I may obtain access to and control the use and disclosure of this information.

**Signature of Patient or Representative**: _____ **Date**:_____

Name of Personal Representative:_____ (Printed)
(If Applicable)

Relationship to Patient:_____
(If Applicable)

## Reports to NYS Immunization Information System — Box 3

I hereby authorize LIFQHC to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

**Signature of Patient or Representative**: _____ **Date**: _____

# RHIO CONSENT FORM
## Long Island Federally Qualified Health Centers
## "LIFQHC"

In this Consent Form, you can choose whether to allow LIFQHC to obtain access to your medical records through a computer network operated by HEALTHIX which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow LIFQHC to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, LIFQHC's staff involved in my care may see and get access to all of my medical records through HEALTHIX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, LIFQHC may not be given access to my medical records through HEALTHIX for any purpose."

RHIOs is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask LIFQHC for it, or go to the website www.ehealth4ny.org.

**Please carefully read the information on the back of this form before making your decision.**

**Your Consent Choices**. You can fill out this form now or in the future. You have two choices.

- ☐ **I GIVE CONSENT for LIFQHC to access ALL of** my electronic health information through HEALTHIX in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for LIFQHC to access** my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.

  **NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHIX.**

| | |
|---|---|
| _____ | _____ |
| Print Name of Patient | Patient Date of Birth |
| _____ | _____ |
| Signature of Patient or Patient's Legal Representative | Date |
| _____ | _____ |
| Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable) |

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

| Patient Name | Date of Birth | Medical Record Number |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

□ Medical Record form (insert date) _____to (insert date)_____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

□ Other:_____ _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

_____ **Genetic Testing**

**Authorization to Discuss Health Information**

(b). □ By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm or Governmental Agency Name)

| 10. Reason for release of information:<br>□ At request of individual<br>□ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**