

HHLI 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 does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

STUDENT INFORMATION	PARENT/ GUARDIAN INFORMATION
<p>Student First Name: _____</p> <p>Student Last Name: _____</p> <p>Date of Birth: ____/____/____ Grade: _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Student Address: _____</p> <p>_____</p> <p style="text-align: center;"><i>City State Zip Code</i></p> <p>Student Cell Phone: _____</p> <p>Student Email: _____</p> <p>*Student Social Security Number: _____ - _____ - _____ (* optional field: Used for insurance purposes only)</p> <p>Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>List the student's primary care provider, if they have one</p> <p>Name: _____</p> <p>Telephone: _____</p> <p>Address: _____</p>	<p>Last Name: _____ First Name: _____</p> <p>Date of Birth: ____/____/____</p> <p>Home/Work Tel: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Last Name: _____ First Name: _____</p> <p>Date of Birth: ____/____/____</p> <p>Home/Work Tel: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>If legal guardian, relationship to the student: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____</p> <p>Preferred Language of Parent/ Guardian: _____</p>
ADDITIONAL EMERGENCY CONTACT	
<p>Name: _____</p> <p>Relationship to Student: _____</p> <p>Phone Number: _____</p>	
PHARMACY INFORMATION	
<p>Indicate the Pharmacy where we can send prescriptions.</p> <p>Pharmacy: _____</p> <p>Pharmacy Address: _____</p> <p>Pharmacy Tel: _____</p>	
INSURANCE INFORMATION	
<p><i>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.</i></p>	
<p>Does your child have other health insurance?</p> <p><input type="checkbox"/> Yes, Health Plan Name: _____ Member ID / Policy Number: _____</p> <p>Does your child have Medicaid? <input type="checkbox"/> Yes, Medicaid ID#: _____</p> <p><input type="checkbox"/> No, My Child does not have Health Insurance.</p>	
<p>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.</p> <p>If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
BOX 1: PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES	
Please read Box 1	
<p>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 School-Based Health Center of LIFQHC. 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.</p>	
<p>X _____</p> <p style="background-color: yellow;">Signature of Parent/Guardian</p>	<p>_____</p> <p style="background-color: yellow;">Date</p>

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 HHLI School-Based Health Program and low cost care at the HHLI 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 HHLI 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

**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 Harmony Healthcare Long Island (HHLI) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by HHLI 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

I hereby authorize HHLI 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
Harmony Healthcare Long Island
"HHLI"

In this Consent Form, you can choose whether to allow HHLI 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 HHLI 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, HHLI'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, HHLI 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 HHLI 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 HHLI 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)

