To be filled out by the SBHC staff.

Medical Record#_____ ID# (to be assigned by SBHC): _____

Branford School Based Health Centers
Permission Form

Please complete and sign this form and return to your child's School Based Health Center.

Today's Date: _____ **Grade:** _____ **School:**_____

Student's Name: _____ **Sex:** Female Male
Last First M.I.

Home Address: _____ **City:**_____ **Zip:** _____

Student's Social Security #: _____ **Birth Date:** _____

Child's Ethnicity: Hispanic/Latino _____ Not Hispanic/Latino _____ **Religion:** (optional) _____

Child's Race: Black or African American _____ White_____ Asian_____ American Indian or Alaskan Native_____
Native Hawaiian/Other Pacific Islander_____ Unknown _____ Other _____

PARENT INFORMATION:

Mother: _____ Father: _____

Address: _____ Address: _____

Home Ph: _____ Work: _____ Home Ph: _____ Work: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

Parents: Married _____ Divorced _____ Separated _____Mother Deceased _____ Father Deceased _____

Guardian of Student: _____ Relationship to Student: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: (please note how the person is related to your child)

Name _____Phone: _____ Relationship _____

Number of people in household: _____ Need Interpreter? Yes____No____ Preferred Language_____

Does your child receive a free or reduced school lunch program? Yes_____No ____Unknown _____

Health Care Provider: Primary Care Physician_____ Phone #: _____

Dentist: _____ Preferred Pharmacy: _____

Insurance Information: ***Please provide a copy of your current insurance card(s) to the SBHC office.****

Insurance Company _____

Address/Phone _____

Policy #_____ Group Name and # _____

Policy Holder's Name _____ Birth Date: _____S.S.#_____

Relationship to Student _____ Occupation:_____

Insurance Type: (Please check one) Husky A___ Husky B____ No Insurance ____Private/Commercial ____Unknown____ Other _____

Employer Name _____ Phone: _____

Employer Address: _____City:_____State: _____Zip: _____

STUDENT'S MEDICAL HISTORY Please check all that apply and explain if your child has a history of the following:

- ❑ Heart Problems
- ❑ Headaches
- ❑ Weight Problems
- ❑ Asthma
- ❑ Heart Murmur
- ❑ Stomach Problems
- ❑ Vision Problems
- ❑ Allergies
- ❑ Dental Problems/Needs
- ❑ Skin Problems
- ❑ Ear Infections
- ❑ Diabetes (Insulin Yes No)
- ❑ Chicken Pox (Year:_____)
- ❑ Upper Respiratory Infections
- ❑ Musculoskeletal Problems
- ❑ Other

Explain:_____

_____

_____

_____

Please answer the following questions. If yes, please explain. Is your child currently or have they had -

Y N Allergies to food, medicine, or other:_____

Y N Taking medications regularly (please list medications and dose): _____

Y N Hospitalizations/surgeries:_____

Female Students:
Has your child begun menstruating? Yes____No _____ If no, have you discussed menstruation with her? Yes ____ No _____

STUDENT'S BEHAVIORAL HEALTH HISTORY Please check all that apply and explain if your child has a history of the following:

- ❑ Anxiety
- ❑ School Attendance Problems
- ❑ Behavior Problems
- ❑ PDD/Autism
- ❑ ADHD/ADD
- ❑ Eating Disorders/Weight Problems
- ❑ Depression/Sadness
- ❑ Sleep Problems
- ❑ Alcohol/Drug Use
- ❑ OCD
- ❑ Academic Concerns

Explain:_____

_____

_____

_____

Y N **Currently in counseling:** Therapist/Provider _____

Y N **Current Agency Involvement:** _____

Y N **History of counseling:** Dates _____

Therapist/Provider _____

Please note any concerns that you would like to discuss with the School Based Health Center staff:

_____

_____

_____

I give my consent for (Student's Name)_____ to receive medical and/or mental health services at Branford SBHCs. I understand all services are confidential in accordance with Connecticut State laws, except in life-threatening or emergency situations. I give permission for the release and exchange of information between the SBHC staff and my child's health care provider. I also give permission for the SBHC staff to communicate with school personnel and to access my child's school and health record.

I authorize Yale-New Haven Hospital to bill my insurance carrier and to release information regarding my treatment and/or services for the purpose of billing. I will not be responsible for paying for any service received at the SBHC. I understand that all medical records are the property of Yale New Haven Hospital. I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I can withdraw my consent to treat at any time through written notification.

Parent/Guardian's Signature:_____Date:_____

YALE NEW HAVEN HEALTH SYSTEM
& YALE UNIVERSITY

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. If you have any questions, please contact our privacy office at the phone number at the bottom of this notice.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to improve treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies. Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protection. For more information on research and how to opt out of research use of your records see www.yalestudies.org or 1-877-978-8343.

If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

In any other situation not covered by this notice, including the use or disclosure of psychotherapy notes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Who will follow this notice?

Yale New Haven Health System (YNHHS) and Yale School of Medicine (YSM) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of our locations
- All departments and affiliated covered entities of Yale New Haven Health System, including; Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group, and Yale-New Haven Hospital
- Yale School of Medicine
- The clinical care providers of Yale School of Nursing as well as their affiliates
- All employees, medical staff, affiliates, trainees, students, or volunteers of the entities listed above

While each of these facilities and affiliates operates independently, they may share your health information for coordination of care, treatment, payment, and healthcare operations purposes.

Right to Be Notified of a Breach:

We will notify you in the event that the confidentiality of your information has been breached.

Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in advance, in writing. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure and certain other exceptions. as required by law.

To request this list of disclosures, indicate the relevant period which must be within the past six years. You must submit your request in writing to the Medical Record or Billing Department as appropriate.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it unless all of the conditions below are met:

- You request that your information is not shared with an insurer for purposes of payment or other purposes unrelated to your treatment;
- You pay all charges associated with the services you received out-of-pocket in full; and
- We are not required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at yalenewhavenhealth.org. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

YNHHS OFFICE OF
PRIVACY AND COMPLIANCE
203-688-8416
Toll Free: 1-888-688-7744
privacy@ynhh.org

Yale University HIPAA
Privacy Office
203.432.5919
hipaa@yale.edu

YALE NEWHAVEN HEALTH SYSTEM

Acknowledgement of Receipt of Notice Of Privacy Practices

Printed Name of Patient: _____

Patient's Medical Record Number: _____

Patient's Date of Birth: _____

Patient's Address: _____

Patient's Personal Representative & Relationship: _____

Signature: _____

Date: _____

If Applicable, Reason for Patient Refusal to Sign: _____

_____