School-Based Health Center
Consent Form

I give consent for my son/daughter to receive health services, including mental health services if appropriate/necessary, at the Student Health Center ("Health Center") at his/her school.

I authorize a nurse practitioner/physician's assistant and other designated health care professionals to provide necessary examination, medical tests, evaluations, diagnostic assessments, individual counseling and management of my child's health care in accordance with the laws of the Commonwealth of Massachusetts. I authorize the use and disclosure of my child's protected health information by the Health Center for purposes of treatment, payment, health care operations and other permitted uses under the HIPAA Privacy Rules. I authorize my child's primary care provider to share clinical information, as appropriate, with the Health Center staff for support treatment for my child, and I give permission to the Health Center staff to share information with the primary care provider as appropriate. I authorize any referral to my child's primary care provider for health care that cannot be provided on site. I understand that the Health Center records, including mental health records, will be locked up and maintained as confidential medical records, separate from school records. I also understand that I may request the release of my child's medical information at anytime.

I understand that I may, at any time during my child's enrollment at his/her school, withdraw this consent. Otherwise, it will apply for the duration of my child's enrollment in the school. I authorize the release of information contained in this form to the Massachusetts Department of Public Health for the purpose of determining my child's eligibility for publicly-funded health insurance programs.

Student Name: ______________________________ Date of Birth: ____________

Address: Street/Apt.#: ______________________________ Zip: ____________

Home Phone#: ______________________________ SS#: ____________

Parent/Guardian Name: ______________________________

Parent /Guardian Address (if different than student): ____________ Zip: ____________

Parent/Guardian Phone#: ________ Work#: ____________ Cell#: ____________

Parent Email (optional for sending periodic information about health center): ______________________________

Parent/Guardian Signature: ______________________________ Date: ____________

Insurance Information (Complete <u>either</u> A, B or C)

A. Private Insurance

Health Insurance Company: ______________________________

Policy#: ______________________________Group#: ____________

B. Mass Health/Medicaid: Medicaid ID#:______________________________

C. No Insurance (check here): ________

Does this student have a regular medical provider or clinic? ________Yes ________ No

If yes, name of medical provider: ______________________________ Clinic Name: ____________

Address: ______________________________ Phone#: ____________