Revised 08/2021

KU Wichita USD 261 Haysville / School-Based Health Care
Parental Consent Form to Receive Health Care Services

STUDENT INFORMATION

Student's Last Name: ______________________

Student's First Name: ______________________

Date of Birth: ______________________

School attending: ______________________

Grade: ______________________

Student's Social Security Number: ______________________

Biological sex: ❑Male ❑Female ❑Decline to answer

Race (check all that apply):❑Black ❑White ❑American Indian
❑ Asian/Pacific Islander ❑ Other ______________
❑ Decline to answer

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino
❑ Decline to answer

Student Address:______________________

____

______________ ______ ______________
City *State* *Zip Code*

Student cell number: ______________________

Does the student have a primary care doctor? ❑ Yes ❑ No
If yes, who is the student's primary care doctor?

Name:______________________

Telephone:______________________

Address: ______________________

PARENT/GUARDIAN INFORMATION

Parent:

Last Name:______________First Name: ______________

Date of Birth: ______________Home Tel: ______________

Work Tel:______________Mobile: ______________

Email: ______________________

Additional Parent:

Last Name:______________First Name: ______________

Date of Birth: ______________Home Tel: ______________

Work Tel:______________Mobile: ______________

Email: ______________________

Legal Guardian (other than parent), If Applicable

Last Name:______________First Name: ______________

Relationship of legal guardian to student: ______________

Date of Birth: ______________Home Tel: ______________

Work Tel:______________Mobile: ______________

Email: ______________________

Additional Emergency Contact whom I give permission for my student's protected health information to be disclosed:

Name:______________________

Relationship to Student: ______________________

Home Tel:______________Work Tel: ______________

Mobile: ______________________

INSURANCE INFORMATION

Does your child have Medicaid?

❑No ❑Yes: Medicaid ID # ______________________

Which Plan?
❑ KanCare – Sunflower Health Plan
❑ KanCare – UnitedHealthcare Community Plan of Kansas
❑ KanCare – Aetna Better Health of Kansas

If able, please attach a copy of your insurance card to this form.

Does your child have coverage through your employer or any other type of health insurance?

❑No ❑Yes, Health Plan: ______________________

Policy Holder's Name: ______________________

Policy Holder's Date of Birth: ______________________

Member ID/Policy Number: ______________________

Health Insurance Phone: ______________________

If able, please attach a copy of your insurance card to this form.

PARENTAL CONSENT FOR HEALTH CENTER SERVICES

I have read and understand the services listed on the next page (Health Center Services) and my signature provides consent for my child to receive services provided by the KU Wichita USD 261 Haysville Health Clinic. Parental consent is not required for students who are 18 years or older or for students who are legally emancipated.

NOTE: Per state law, statute 38-123b: "*Notwithstanding any other provision of the law, any minor sixteen (16) years of age or over, where no parent or guardian is immediately available, may give consent to the performance and furnishing of hospital, medical or surgical treatment or procedures and such consent shall not be subject to disaffirmance because of minority. The consent of a parent or guardian of such a minor shall not be necessary in order to authorize the proposed hospital, medical or surgical treatment or procedures.*"

X ______________________________ ______________

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X ______________________________ ______________

Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

Revised 08/2021

KU Wichita USD 261 Haysville
Parental Consent Form to Receive Health Center Services

HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of KU Wichita USD 261 Haysville and understand this may include learners working under the licensure of the supervising physician, APRN, or PA-C. I understand that confidential- ity between the student and the health provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Health Clinic services may include, but are not limited to:

1. Screening for vision, hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for infections, anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medi- cations.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the health center.
8. Screening questionnaires.

KU Wichita USD 261 Haysville
PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on the reverse side of this form authorizes release of medical information. This information may be shared for: (1) your stu- dent's treatment, including disclosure to school personnel involved in my student's health care including but not limited to the school nurse, health aide, social worker, counselor, and mental health care provider on campus to the extent required to provide quality, comprehensive medical care; (2) for billing and payment purposes; and (3) Primacy Care Physician.

I acknowledge I have received a copy of KU Wichita Medical Practice Associations' Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that KU Wichita Medical Practice Association may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact KU Wichita Medical Practices' Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my student's health information for the purposes described in the Notice of Privacy Practices.

In addition to the above, information about your student can be shared as part of reporting child or adult abuse and/or neglect or other ex- ceptions included in Kansas law.

Consent to bill insurance and responsible party

I understand that the health clinic needs to cover its expenses and therefore bills for services rendered. This includes billing third parties such as any applicable health insurer. I further understand that as the responsible party for my student, I will be billed directly for health services provided by KU Wichita USD 261 Haysville that are not covered by my by insurer as listed on the reverse side of this form. I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred on behalf of my student not covered by my insurance. If I have concerns regarding billing, I understand that I should contact KU Wichita Medical Practice Association at (316) 293-3429 and not USD 261 or the school where health services were provided.

Disclosure of Health History

I have reviewed the attached health history form with my student and completed their health history.

Please list any individuals that (in addition the Emergency Contact listed on page 1) you authorize us to discuss your student's healthcare with.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Responsible Party Signature ______________________ Date ______________________

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice or want more information, please contact our Privacy Officer at (316) 293-2620.The effective date of this notice is June 7, 2013.

KU School of Medicine – Wichita Medical Practice Association ("MPA") collects individually identifiable information about you in the course of providing services to you. We may use and disclose your health information without your express consent or authorization for some purposes, while other purposes require us to obtain your express written authorization before using or disclosing your information. You may revoke such authorization, in writing, at any time to the extent MPA has not relied on it.

We must give you this Notice about our privacy practices and follow these practices. We may update this Notice to show any changes in our privacy practices. The new Notice will be effective for all protected health information that we maintain. We will post a copy of the current Notice in places where you receive services. You may request a copy of the revised notice by calling MPA or asking for one at the time of your next appointment.

HOW MPA MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information without an authorization for treatment, payment, and health care operations.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside MPA involved in your treatment, such as other health care providers, family members, and friends.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

We may disclose and use your health information and you authorize us to use and disclose your information for:

Appointment Reminders. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.

Treatment Alternatives. We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

Business Associates. MPA provides some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of de-identified health information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your health information when required by law to do so.

Disclosures for public health activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. MPA may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Research. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.

Health Oversight Activities. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official’s request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Deceased Individual. We may disclose information for the identification of the body or to determine the cause of death.

Military and Veterans. If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Organ and Tissue Donation. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

We will give you the opportunity to object to the following uses and disclosure of your information:

Notification. We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.

Disaster Relief. We may disclose information about you to public or private agencies for disaster relief purposes.

Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.

Marketing. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.

Sale of Information. We will not sell your Protected Health Information without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to us and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by MPA. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request this list, you must complete a specific form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific form providing information we need to process your request. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. We are not otherwise required to agree to any restriction on the use or disclosure of your information. MPA’s Privacy Officer is the only person who has the authority to approve such a request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. MPA’s Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Notice of Privacy Practices. You have the right to request a paper copy of this Notice.

OUR DUTIES.

We are required by law to maintain the privacy of Protected Health Information and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.

We are required to notify you if there is a breach of your unsecured Protected Health Information.

We are required to follow the terms of the current Notice.

We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

COMPLAINTS.

If you believe your rights with respect to health information have been violated, you may file a complaint with MPA or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with MPA, **please contact Privacy Officer, KU School of Medicine – Wichita Medical Practice Association, 1010 N. Kansas, Wichita, Kansas 67214 or at (316) 293-2620**. We request complaints be submitted in writing. **You will not be penalized for filing a complaint**.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Or by calling: 1-877-696-6775
Or visit: https://www.hhs.gov/hipaa/filing-a-complaint/

We will not retaliate against you for filing a complaint.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION EXCHANGE.

KU School of Medicine – Wichita Medical Practice Association (MPA) participates in the electronic exchange of health information with other healthcare providers and health plans in the State of Kansas through an approved health information organization (HIO). Through our participation, your PHI may be accessed by other providers and health plans for the purposes of treatment, payment, or health care operations. MPA may use other providers' information in the coordination of care. The approved HIO is required to maintain safeguards to protect the privacy and security of PHI. The approved HIO may only allow authorized personnel to access PHI through the HIO.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information through an HIO. You have two choices. First, you can permit authorized individuals to access your PHI maintained through an HIO for treatment, payment, or health care operations. If you choose this option, you do not have to do anything.

Second, you can restrict access to your PHI maintained through an HIO. To do so you must submit a request to opt out of HIE through the Kansas Health Information Exchange, Inc. by visiting www.khie.org or calling the KHIE Support Center at (785) 783-8984 for more information. You can restrict KU School of Medicine – Wichita Medical Practice Association from making your PHI available to the HIO by following instructions at the section above, "Right to Request Restrictions". Even if you restrict access through (or opt out of participating in) an HIO, providers and health plans may share your information through already available other legal means without your specific authorization.

Please understand your decision to restrict access to your electronic health information through an HIO may limit your health care providers' ability to provide the most effective care for you. By submitting a request for restrictions, you accept the risks associated with that decision.

END