Arkansas Children's
HOSPITALS · RESEARCH · FOUNDATION

Arkansas Children's Hospital
School–Based Health Clinic Consent

Student Name:_____Birthdate:_____Gender:_____

Legal Guardian: _____Relationship:_____

Address: _____Zip Code:_____

Phone Number:_____Preferred Pharmacy:_____

Family Doctor:_____City: _____Telephone: _____

Insurance (check one):___ Medicaid ___ ARKIDS First ___ Other Insurance:_____ID: _____

School Name: _____Teacher Name: _____Grade: _____

Please read each statement:

- I understand that the following types of health care may be offered to my child by Arkansas Children's Hospital (ACH) through the School–Based Health Clinic (the "Clinic"):
  - Routine physical exams and sports physicals
  - Care when my child is sick or has health problems
  - Care for minor wounds
  - Eyesight, hearing, teeth, and blood pressure checks
  - Some shots
  - Lab tests
  - Health education and counseling
  - Teaching good eating habits and weight control
  - Prescription drugs
  - Classroom presentations
  - Referrals to a provider of your choice for care not given at the Clinic

- I am the parent or legal guardian of the student named above. I give my permission for the Clinic to give the care listed above to my child.

- No guarantees have been made to me about the results of health care at the Clinic.

- I allow my child's health information to be sent as needed to the referring office or doctor and/or family doctor, to handle medical insurance claims, and for audits (checks) to back up these claims.

- I understand that no student will be turned away from the Clinic, even if he or she cannot pay for needed care.

- I also understand that, if my child has insurance or Medicaid, the insurance company or Medicaid may be billed for the care given to my child.

- I will allow payment for Clinic services my child receives to be paid directly to the Clinic provider, ACH, the billing company, and/or the doctor. I allow these parties to do what is necessary to collect these benefits directly from my insurance.

- I understand that this form expires 1 year from the date signed.

- I understand that I may revoke/withdraw this Consent at any time by giving written notice to ACH Community Clinical Program, Slot #608, 1 Children's Way, Little Rock, AR 72202. A revocation/withdrawal of this Consent will not apply to medical services provided prior to ACH receiving the written notice of withdrawal.

I have read all items on this Consent and (check one):

_____ CONSENT to medical services for the student patient named above through ACH School–Based Health Clinic.

_____ DO NOT CONSENT to medical services for the student patient named above through ACH School–Based Health Clinic.

Signature:_____Date: _____

CONS.FRANKLIN

Arkansas Children's Hospital
Health Information Management
1 Children's Way Slot 109
Little Rock, Arkansas 72202
Release of Information
501-364-1268 Fax: 501-364-3968

For Official Use Only: MR#: _____ **Acct #:** _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO SCHOOLS

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. Who is authorized to disclose the information? **Arkansas Children's Hospital AND Healthcare providers and those providing health services (school nurse, occupational therapist, speech therapist, physical therapist, etc.) within** Little Rock School District **School District**

2. Who is authorized to receive the information?

Arkansas Children's Hospital

Arkansas Children's Hospital
#1 Children's Way Slot 109
Little Rock, Arkansas 72202

AND

Healthcare providers and those providing health services within Little Rock **School District**
(please include patient's school address below)

_____
_____
_____, _____ _____

3. The specific information to be requested or released is:

List the dates of service:

☒All ❑__/__/____ to ___/__/____ ❑HOLD for pending appointment

❑Discharge Summary
❑History & Physical
❑Discharge Instructions
❑ ER Report
❑ Clinic Reports
❑ Treatment Action Plans
❑ Other: _____

4. The information is needed for:
Continuity of Care and any necessary preparation or instruction needed in the school environment

5. I understand that if the person or entity that receives the information is not a covered entity under the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires: 1 year from date signed.

8. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

Witness:_____Phone Number:_____Date:_____

ARKANSAS CHILDREN'S HOSPITAL

JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Joint Notice of Privacy Practices for Arkansas Children's Hospital, University of Arkansas for Medical Sciences, and the ACH Medical Staff.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

This document will become a permanent part of the patient's Medical Record.

Please forward to Medical Records.

JOIN.NOT.EN

- **Business Associates.** We may share some of your PHI with outside people or companies who provide services for us, such as typing physician reports.
- **Patient Directory.** Unless you tell us not to, we may disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation may also be given to members of the clergy.
- **Notification.** We may use or disclose PHI to notify a family member or other person involved in your care, your location and general condition unless you tell us not to do so.
- **Communication with Family.** A doctor, nurse or other healthcare worker may share PHI with a family member, a close personal friend, or a person that you identify, if they are involved in your care or in payment for your care, unless you tell us not to do so.
- **Research.** Your PHI may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board, known as an Institutional Review Board (IRB), whose members review and approve the research project. In certain circumstances, the IRB may determine your authorization is not necessary and issue a waiver. In all other instances, your authorization (permission) is required for the disclosure of your PHI for research.
- **Coroners, Medical Examiners, Funeral Directors.** We may disclose PHI to these people, to the extent allowed by law, so that they may carry out their duties.
- **Organ Donor Organizations**. If you are an organ donor, we may share your PHI with the organ donation agency for the purpose of tissue or organ donation in certain circumstances or as required by law.
- **Fundraising.** Our Foundation may use information to notify you about fundraising campaigns or other charitable events to raise money for ACH and/or ACNW. You have the right to opt out of fundraising communications and may do so by calling 1-800-880-7491 or emailing giving@archildrens.org or achfdn@archildrens.org.
- **Marketing.** In certain circumstances, we may contact you as part of our marketing efforts. We may use your PHI for marketing purposes without your authorization only when we discuss such products or services with you face-to-face or provide you with a gift of nominal value related to the product or service. For other types of marketing activities, we will obtain your written authorization. Providing you information or refill reminders for a drug you are currently taking is not considered marketing.
- **Sale of Information.** We will not sell your information without your prior written authorization or as otherwise allowed by law.
- **Food and Drug Administration (FDA).** We may share your PHI with certain government agencies like the FDA so they can recall drugs or equipment.
- **Workers Compensation.** We may disclose your PHI for workers' compensation claims.
- **Public Health.** We may give your PHI to public health agencies who are charged with preventing or controlling disease, injury or disability or as required by law.
- **Communicable Disease.** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Correctional Institution.** If you are an inmate of a correctional institution, we may disclose your PHI to the institution or law enforcement as needed for your health or the health and safety of others.
- **Law Enforcement.** We may disclose your PHI for law enforcement purposes as required by law.
- **As Required by Law.** We must disclose your PHI when required by federal, state or local law.
- **Health Oversight.** We must disclose your PHI to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the health care system, government benefit programs, such as Medicaid, and other government regulatory programs.
- **Abuse or Neglect.** We must disclose your PHI to government authorities that are authorized by law to receive reports of suspected child abuse or neglect involving children or endangered adults.
- **Legal Proceedings.** We may disclose your PHI in the course of any judicial or administrative proceeding, in response to a court order, and in certain conditions, in response to a subpoena, discovery request or other lawful process, as allowed by law.
- **Required Uses and Disclosures.** We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the HIPAA Privacy Regulations.
- **To Avoid Harm.** We may use and disclose your information, when necessary, to prevent a serious threat to your health or safety or the health and safety of the public or another person.
- **For Specific Government Functions.** In certain situations, we may disclose PHI of military personnel and veterans. We may disclose PHI for national security activities required by law.
- **Other Uses of Medical Information.** Any use or disclosure of medical information not covered by this Notice or the laws that apply to such use or disclosure will be made only with your written authorization (permission). You may cancel this authorization at any time, but you must put this in writing. If you cancel this authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization unless we are required to do so by law. We are unable to withdraw any disclosures we have already made.

Revised December 2017

Joint Notice of Privacy Practices

Arkansas Children's Hospital
Arkansas Children's Northwest
Arkansas Children's Medical Group
Arkansas Children's Hospital Medical Staff
Arkansas Children's Northwest Medical Staff
University of Arkansas for Medical Sciences

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Effective Date: February 19, 2018

Purpose of the Joint Notice of Privacy Practices

This Notice is provided on behalf of Arkansas Children's Hospital (ACH), Arkansas Children's Northwest (ACNW), Arkansas Children's Medical Group (ACMG), the University of Arkansas for Medical Sciences (UAMS) and the members of the ACH and ACNW Medical Staffs.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting your medical information. We create a record of the care and services you receive at ACH, ACNW and our clinics ("Arkansas Children's"). We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and disclose your protected health information. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information.

Most of the patients at Arkansas Children's are children. When we refer to "you" or "your" in this Notice, we refer to the patient. When we refer to types of disclosures of information to "you," we mean disclosures to the patient, the patient's guardian, or the person legally authorized to receive information about the patient.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. "Protected Health Information" (PHI) is information about you or your minor child, including demographic data such as name, address, phone numbers, and other identifying information that may identify you and that relates to your past, present or future physical or mental health and related health care services.

We are required to give you this Notice and to maintain the Privacy of Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. **This Notice may be accessed on the Arkansas Children's web page www.archildrens.org and will be posted in prominent areas of our facility.**

You may receive a revised copy by sending a written request to:
Arkansas Children's Privacy Officer, Arkansas Children's Hospital
1 Children's Way, Slot 681, Little Rock, AR 72202

You may complain to us or to the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us, you may send a letter describing the violation to:
Arkansas Children's Privacy Officer, Arkansas Children's Hospital,
1 Children's Way, Slot 681, Little Rock, AR 72202
There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the Arkansas Children's Privacy Officer at 501-364-4368.

Who Will Follow This Notice?

This Notice describes the practices of: ACH and ACNW healthcare professionals authorized to enter information into your records, ACH and ACNW employees, ACH and ACNW medical staff, volunteers and other ACH and ACNW clinic personnel, students-in-training on the ACH or ACNW campus, members of the Organized Health Care Agreement: UAMS and ACMG doctors, UAMS medical students, UAMS and ACMG nurses, and other UAMS and ACMG employees who work or provide health care services on the ACH and ACNW campuses.

Your Health Information

You have the following rights relating to your protected health information and may:

- Obtain a paper copy of this Notice
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions, unless you are requesting to restrict certain information from your health plan and you or someone on your behalf has paid for your ACH and/or ACNW services in full. Both the request for the restriction and the payment in full must be made prior to any of the services being provided.
- Make a reasonable request to receive confidential communications of your PHI from us by alternative means or at alternative locations.
- Inspect or obtain a copy of records (in paper or electronic form) used to make decisions about you. You will be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you may ask for a review of this denial by a licensed healthcare professional identified by Arkansas Children's who was not involved in the original denial decision. We will comply with the outcome of this review. We can deny access to psychotherapy notes.
- Request that we amend your record, if you feel the information is incomplete or incorrect; however, we are allowed to deny this request in certain circumstances. We may ask you to put these requests for amendments in writing and provide a reason that supports your request.
- Obtain a record of certain disclosures of your PHI.
- Provide us with written authorization (or permission) for uses and disclosures of your PHI that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may revoke (or cancel) this authorization. The request to cancel must be put in writing.
- To inspect or obtain a copy of your records, send a written request to the Director of the ACH Medical Records Department. All other requests must be sent to the Arkansas Children's Privacy Officer.

Our Responsibilities

We are required to maintain the privacy of your PHI, abide by the terms of this Notice, make this Notice available to you, and notify you if a breach of your health information occurs.

Examples of Uses and Disclosures

TREATMENT. Information obtained by a nurse, doctor, or other healthcare worker will be put into the medical record and used to plan and manage your treatment. We may communicate with and provide reports or other information to your doctor or other authorized persons who are involved in your care, including healthcare providers outside of ACH and/or ACNW. We may disclose your PHI to other health care providers, public health reporting entities or health care plans for treatment, payment or operational purposes using Arkansas Children's Care Network, Epic's Care Everywhere, and/or the State Health Alliance for Records Exchange (SHARE) unless you have opted out of participation. PHI may also be shared between ACH, ACNW, ACMG and UAMS as necessary to carry out treatment.

PAYMENT. A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used. We may also disclose limited information about your bill to others to obtain payment. PHI may be shared between ACH, ACNW, ACMG and UAMS as necessary to carry out payment.

HEALTH CARE OPERATIONS. We may use your PHI to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital, medical group or clinic. Also, we may share your PHI, as necessary, to carry out the routine business functions. PHI may be shared between ACH, ACNW, ACMG and UAMS as necessary to carry out health care operations.