



## Learning Well, Inc. Informed Consent for School-Based Health Clinic Services

I give permission for \_\_\_\_\_

**Please print student's: Last Name**

**First Name**

**Middle Name**

to receive health services from the school-based health clinic at my child's school. The school-based health clinic cannot take care of all the health needs my child may have. However, if he or she is not already under the regular care of a doctor or clinic, I will work with the school-based health clinic staff to choose one.

**I. I give consent for my child to receive school-based health clinic services:** I have read the information about the school-based health clinic and the release of information and understand what services the school-based health clinic will and will not provide. **My consent will allow my child to receive health services** (including behavioral and mental health counseling) while he/she is a student at this school. If I change my mind, I must write a letter to the school-based health clinic stating my intentions. It will also be my responsibility to notify the school-based health clinic staff about changes in guardianship, address and phone numbers.

**II. Information Privacy:** We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your child's personal health information. You have the right to review this notice prior to signing this consent. The terms of the notice may change from time to time. The current notice will be posted at our facilities, on our website, and copies will be available for you to take.

\_\_\_\_\_ **(Parent's Initials)** I acknowledge that I have received a copy of the Learning Well, Inc. **NOTICE OF PRIVACY PRACTICES.**

**III. Release of Information:** I understand the services provided by the school-based health clinic are **confidential.** The school-based health clinic will use and disclose my child's personal health information to provide treatment and for improvement of healthcare operations. My child's information may be shared with the school health office (e.g. with my child's doctor or primary care provider); my child's school nurse; my child's school social worker; or with my child's insurance provider for legitimate purposes. I authorize the release of my child's medical information to other physicians and other providers who may have my child as a patient. I also authorize the use of information from my child's medical record for purposes of medical care, treatment, clinic administration and evaluation.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Student:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SERVICES WILL NOT BE PROVIDED WITHOUT PARENTAL CONSENT AS REQUIRED BY THE INDIANA STATE LAW.**