Consent/HIPAA Authorization
School Nurse
Health Clinic Services

School: _____ Grade _____ Effective July 1, 2018 – June 30, 2019

I give permission for _____
Please print students: Last Name, First Name Middle Initial Date of Birth

To receive health services from the school nurse health clinic (Clinic) at my child's school. I understand that Clinic personnel cannot take care of all the health needs my child may have. However, if my child is not already under the regular care of a doctor or clinic, I will work with the Clinic to choose one.

I. I give consent for my child to receive Clinic services: I have read the information about the Clinic and understand what services the Clinic may provide, which include, but are not limited to: first aid/emergency care, referrals to health providers in the community, nutrition services, health education, health screenings and immunization information. It will be my responsibility to notify the Clinic staff about changes in guardianship, the child's living or custody arrangements, and contact numbers.

Signature of Parent or Guardian (if student under age 18): _____ Date: _____
Signature of Student (if 18 or older or emancipated): _____ Date: _____

NURSING SERVICES WILL NOT BE PROVIDED WITHOUT CONSENT AS REQUIRED BY STATE LAW.

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 (PHI). You have the right to receive this notice prior to signing this consent. The current notice will be posted at your child's school, on Community's website, and copies are available upon request by asking the Clinic staff.

_____ **(Parent's Initials)** I acknowledge that I have access to a copy of the **Community Health Network NOTICE OF PRIVACY PRACTICES,** via Community's website. (Paper copies upon request.)

III. Release of Information: I hereby authorize the Clinic to disclose the PHI of student name listed above: The student's PHI that may be disclosed under this Authorization includes records and reports of medical services provided to the student at the Clinic, including but not limited to the evaluation, diagnosis and treatment of the student's injuries and illnesses. The PHI may be disclosed for clinic administration purposes, to the applicable school administration or staff to evaluate the student's eligibility to participate in school activities, or to resolve grievances. In addition, I give my consent to the school-based health clinic staff to look at my child's full school record, including attendance, in order to provide information that may assist the clinic staff in helping my child. I understand that the Clinic will not restrict services to the student based on my decision not to sign this Authorization, but that the student's participation in certain school sponsored activities may be conditioned on the signing of this Authorization.

Expiration of Authorization: As listed above. I understand that I may revoke this Authorization in writing at any time prior to its expiration date, except to the extent that action has been taken by the Clinic in reliance on this Authorization, by sending a written revocation to a member of the Clinic staff. I understand that the PHI released by the Clinic may be subject to re-disclosure by any recipient and no longer protected by federal or state privacy laws.

Signature: _____ **Date:** _____

Signature of Student (if 18 or older or legally emancipated): _____ **Date:** _____

Community Health Network

Indiana State Department of Health
Children & Hoosiers Immunization Registry Program
CHIRP

I,_____ , give [Name of School] , permission to release the following information concerning my child, _____, to the
Name of Child
Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

CHILD'S NAME, IMMUNIZATION DATA, SEX, ETHNICITY, PARENT'S NAMES, ADDRESS, AND PHONE

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed Name of Parent or Guardian

_____ _____
Address Telephone Number

_____ _____
Child's Name Date of Birth

_____ _____
School