Name, MR#, Pat#, DOB

DENVER HEALTH

CONSENT FOR TREATMENT
PARENTAL CONSENT

DENVER SCHOOL-BASED HEALTH CENTER SERVICES (DSBHC)

I give my consent for _____ _____
Child First Middle Last Name Child's Birth Date

to receive necessary and/or advisable health services from staff at the DSBHC. I have received the SBHC flyer explaining the DSBHC services and I understand the following services may be available:

Physical exams and immunizations • Routine lab tests • Care for acute illness and injury • Prescription medications • Care for common adolescent physical concerns (weight, acne, menstrual problems) • Care of certain chronic conditions such as asthma and seizure disorder • Pregnancy testing • Diagnosis and treatment of sexually transmitted diseases • Family planning, administration and management of brith control, and abstinence counseling • Prenatal/postpartum care services • Drug and alcohol prevention and education • Mental health services including individual, family and group therapy • Follow-up care as needed • Dental services, including dental screenings, routine cleanings, sealants, and dental x-rays.

Release of Information: the information in my son's/daughter's medical record is protected health information and will not be released to any unauthorized person or agency without written consent by child's parent/guardian. I understand that DSBHC may disclose health information for payment, treatment, and health care operations as described in DHHA's Notice of Privacy Practices, and otherwise as allowed by law. As allowed by Colorado law, my son or daughter may request that certain visits and health information remain "confidential." This means that, for me or any other party to have access to my child's medical records regarding such information, a written release must be completed by my child. I give my permission for the DSBHC staff to examine and/or copy my son's or daughter's school records including immunization records, attendance, and other records that may assist the staff in helping my son or daughter.

DSBHC Fees, billing, authorization, and consent: On behalf of my child and myself, I hereby assign to Denver Health and Hospital Authority ("DHHA") any and all benefits that either my child or I may be entitled to receive for healthcare services provided by DSBHC from any payer of benefits including any person, entity, insurance company, health benefit plan, or governmental healthcare program. DHHA is authorized to file claims with, and collect payments from, the payer of benefits, and the payer of benefits is directed to make payment directly to, and solely to the order of, DHHA. My child and I agree to assist DHHA in submitting and collecting claims from the payer of benefits in any reasonable manner requested. We authorized DHHA and its care providers to disclose to the payer of benefits any information from my child's medical and billing records necessary to obtain payment. I understand that once such information is disclosed, DHHA will be unable to control its confidentiality.

Child's Name: _____ Sex: ☐ M ☐ F DPS/Lunch ID #: _____

Child's School: _____ Grade: _____

Child's Home Address: _____ Apt: _____ Zip Code: _____

Child's Race/Ethnic Group (optional - please circle one or more): Hispanic or Latino American Indian or Alaska Native Asian

Black or African American Native Hawaiian or Other Pacific Islander White Other: _____

Last 4 digits of Child's Social Security #: _____ Child's Birth Country: _____

Mother/Guardian Name: _____ Phone: _____

Father/Guardian Name: _____ Phone: _____

Other Person to Contact in Emergency: _____ Phone: _____

Child's Medical/Clinic: _____ Phone: _____ MRN: _____

Insurance Information:

My child has medical coverage (including Medicaid or CHP+) ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No Medicaid Number: _____ **CHP+:** ☐ Yes ☐ No Number: _____ **DFAP:** ☐ Yes ☐ No **CICP:** ☐ Yes ☐ No

Private Insurance: ☐ **Aetna** ☐ **Anthem** ☐ **BCBS** ☐ **CIGNA** ☐ **DHMP** ☐ **Great West** ☐ **Kaiser** ☐ **PacifiCare** ☐ **Tri Care**
☐ **United Health Care** ☐ **Other:** _____

Name of Insured (father, mother, other): _____

Employer of Insurance Holder: _____

Name of Insurance Company: _____ Relationship to child: _____

Insurance Policy # / Member #: _____ Group #: _____

This consent will remain in force for a period of 18 months from the date of my signature or until I revoke this consent in writing. It is my responsibility to tell the DSBHC about changes in guardianship or insurance coverage.

Signature of parent/guardian: _____ **Date:** _____

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Name, MR#, Pat#, DOB

DENVER HEALTH

DENVER SCHOOL-BASED HEALTH CENTER IMMUNIZATION CONSENT FORM

Child's name: _____ **Date of Birth:** _____/_____/_____
Last First Middle MM DD YY

Child's School: _____ **Grade:** _____ **Sex:** ☐ Male ☐ Female

Parent or Legal Guardian name: _____

Has your child had the Chicken Pox? ☐ Yes ☐ No If Yes, when? _____/_____/_____
MM DD YY

Has your child ever had a serious reaction to vaccines? ☐ Yes ☐ No

If Yes, what was the reaction and to what vaccine? _____

_____

- **Please read the attached Vaccine Information Statements.**
- **Please tell if you want your child to receive <u>all</u> recommended vaccines by signing the bottom of this page.**
- **Please include a copy of your child's immunization record if available. Your child's immunization record will be reviewed to determine his/her vaccine needs.**
- **This consent is valid for a period of 18 months from the date of signature.**

If you <u>DO NOT</u> want your child to receive any specific vaccine, <u>write "NO"</u> by that vaccine:

<u>Required for School</u>
_____ Polio
_____ Tetanus diphtheria acellular Pertussis (Tdap)
_____ Varicella (Chicken Pox) (series of 2)
_____ Measles, Mumps, Rubella (MMR) (series of 2)
_____ Hepatitis B (series of 3)

<u>Recommended for all children</u>
_____ Meningococcal conjugate (MCV4)
_____ Hepatitis A (series of 2)
_____ Influenza (Flu)
_____ Human Papillomavirus (HPV) (series of 3)

8 3 7

I give my permission for my child to receive all required or recommended vaccinations at school, except for those that say, "no," above. I have read or have had explained to me the information on the Vaccine Information Statements about the disease and the vaccines. I have had a chance to ask questions and my questions were answered to my satisfaction. I understand the benefits and risks of the immunizations and request that those immunizations be given to the student named above, for whom I am authorized to make this request. I further agree to have information shared with my child's primary care provider. I also agree to have my child's immunization record stored in my child's school health record, the Denver Health Immunization system (Vax Trax), and the Colorado Immunization Information System (CIIS).

_____ _____ _____/_____/_____
Parent or Guardian Signature **Relationship to Child** **Date (MM/DD/YY)**

Name, MR#, Pat#, DOB

DENVER HEALTH MEDICAL CENTER
PARENT / GUARDIAN QUESTIONNAIRE
CHILD / TEEN / FAMILY HISTORY

Child / Teen Health History

1. Does your child take **medication**? ☐ No ☐ Yes If yes, what? _____

   _____

2. Has your child had **serious medical** or **mental health problems**? ☐ No ☐ Yes

   If yes, what? _____

3. Has your child been **hospitalized overnight** or had **surgery** or any **serious injuries**? ☐ No ☐ Yes

   If yes, what? _____

4. Does or did your child have any of these problems **now** or in the **past**?

   ☐ Allergies to food, medicine, or anything else?.....if yes, what? _____

   ☐ Asthma
   ☐ Birth Problems
   ☐ Blood Clots/Stroke
   ☐ Cancer
   ☐ Chicken Pox
   ☐ Development/Learning Delays
   ☐ Diabetes
   ☐ Drug / Alcohol Abuse
   ☐ Heart Disease
   ☐ High Blood Pressure
   ☐ High Cholesterol
   ☐ Mental Illness/ Depression
   ☐ Migraines
   ☐ Seizures
   ☐ Sickle Cell Anemia
   ☐ Tuberculosis / TB / Positive TB Test
   ☐ Other _____

Family History

Does anyone in your family (parents, siblings, grandparents, aunts/uncles) have any of these problems, **now** or in the **past**?

☐ Asthma ..... if yes, who? _____
☐ Blood Clots/Stroke..... if yes, who? _____
☐ Cancer..... if yes, who? _____
☐ Diabetes ..... if yes, who? _____
☐ Drug/Alcohol Abuse..... if yes, who? _____
☐ Heart Disease..... if yes, who? _____
☐ High Blood Pressure ..... if yes, who? _____
☐ High Cholesterol..... if yes, who? _____
☐ Mental Illness/Depression ..... if yes, who? _____
☐ Sickle Cell Anemia ..... if yes, who? _____
☐ Tuberculosis / TB / Positive TB Test ..... if yes, who? _____

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_____
Parent/Guardian Signature Date (mm/dd/yy)

_____
Staff Signature/Title Date (mm/dd/yy) Time (00:00) (Pager & Provider #)

DENVER HEALTH
Level One Care for ALL

Name, MR#, Pat#, DOB

DENVER HEALTH AND HOSPITAL AUTHORITY

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

If you have any questions, contact a Patient Representative at 303.602.2915 or the Privacy Officer by phone at 303.436.8886; by fax at 303.602.7024; or by mail at 777 Bannock Street, MC 7776, Denver, CO 80204.
To learn more about Denver Health, please see www.DenverHealth.org.

Medical information about you and your health is private. We strive to protect your health records when you are in the hospital and when you are being seen in the clinics. We will use your records to care for you, to bill for care, to run the hospital, and to comply with the law. This Privacy Notice applies at all Denver Health and Hospital Authority (Denver Health) inpatient, outpatient, community clinic, and emergency services sites except for parts of the Rocky Mountain Poison and Drug Center and Denver Public Health, which do not have to follow this Notice.

This Notice tells you about the ways Denver Health may use or give out information from your private health records. It also explains your rights and our responsibilities.

Who Follows The Terms of This Notice

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical information to do their jobs

Acknowledgement of Receipt

I understand that, as allowed and required by law, Denver Health staff will use and give out my health records, without my consent or authorization, for:

- **Treatment:** Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- **Payment:** Denver Health will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- **Healthcare Operations:** Denver Health will use my health records to run the hospital and clinics and to make sure patients receive quality care.

Otherwise, Denver Health will follow the restrictions in this Notice of Privacy Practices.

I acknowledge that I have received a copy of Denver Health's Notice of Privacy Practices.

_____ _____
Patient/Legal Representative Date

_____
Legal Representative's Relationship

_____ _____
Witness Date

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an Electronic or Paper Copy of Your Medical Record.
You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. To see or get a copy of your records, please talk to the staff where you get your care or the Medical Records Department at 303.602.8001. You may be asked to fill out a form. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

In some cases, we may deny your request to read or get a copy of your records. We will give you the reason for the denial. If your request is denied, you can ask that the denial be reviewed. A care provider chosen by Denver Health will review your request. This person will not have taken care of you or have been involved in the first review. We will follow what they decide.

Ask Us to Correct Your Medical Record.
You can ask us to or correct health information about you that you think is incorrect or complete.
To ask for a correction, please talk to your care provider, staff where you receive care, or the Medical Records Department at 303.602.8001. You may be asked to fill out a form and to give a reason for your request. We may say "no" to your request, but we will tell you why in writing within 60 days.

Ask for Confidential Communications.
We may contact you to remind you about an appointment, to tell you your test results, to give you information about services that may be of help or interest to you, or for other reasons related to your health. You can ask that we contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

To ask for specific confidentiality, talk to your care provider or staff where you receive care. We will not ask you the reason for your request. You must tell us how or where you want to be contacted.

Ask Us to Limit What We Use or Share.
You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

To ask us to limit how we use or give out your health information, talk to your care provider or staff where you receive care, contact the Medical Records Department at 303.602.8001 or contact the Privacy Officer at 303.436.8886. You may be asked to fill out a form.

Get a List of Those with Whom We Have Shared Your Information.
You can ask for a list (accounting) of the times we have shared your health information for six years before the date you ask, who we shared it with, and why. We will include all of the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

To ask for this list, please call the Medical Records Department at 303.602.8001. You will be asked to fill out a form. You can get one list free a year, but we will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a Copy of this Privacy Notice.
You can ask for a paper copy of this Notice at any time, even if you already have one. We will provide you with a paper copy promptly, and it is always available on our website at www.denverhealth.org.

Choose Someone to Act for You.
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a Complaint if you Feel Your Rights are Violated.
You can complain if you feel we have violated your rights. All complaints must be given to us in writing. Mail to: Privacy Officer, 777 Bannock Street, MC 7776, Denver, CO 80204. Fax to: 303-602-7024. You can also make a complaint to the Secretary of the Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint and your care will not be affected.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation, such as the Red Cross, so that your family can be called or told about your health status.
- Include your information in a hospital directory so your family and friends who ask for you by name can call or visit you and so that you can get mail and flowers. If you do not object, we will include your name, your location, and your general condition. Also, you can tell us your religion if you want, and members of the clergy who ask to visit patients of your religion will be given your name.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- Most sharing of alcohol and drug abuse treatment information maintained by Denver Health's federally assisted substance abuse treatment programs

Fundraising.
We may use your information to contact you in an effort to raise money for Denver Health. We may share this information with our affiliated Denver Health Foundation to work on our behalf. If you do not want to receive communications about fundraising (to opt out), or you wish to opt back in, call the Foundation at 303-602-2970, or send an e-mail to: dhfoundation@dhha.org.

Colorado Regional Health Information Organization (CORHIO). CORHIO is a nonprofit organization of hospitals and doctors whose mission is to improve health care by allowing participating hospitals and doctors to exchange medical information electronically between them. This allows all of your care providers at different organizations to view your health information so that they can make better decisions about your care. If you do not want Denver Health to share your information with other participating hospitals and doctors through CORHIO, you can "opt out" by writing to the Denver Health CORHIO Point of Contact, 301 W 6th Avenue, MC 0296, Denver, CO 80204.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We typically use or share your health information in the following ways:

Help Manage the Health Care Treatment You Receive.
We can use your health information and share it with professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Bill for Your Health Services.
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

Run Our Organization.
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services and to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help With Public Health and Safety Issues.
We can share your health information for certain situations such as:
- Preventing disease
- To report births and deaths
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence and victims of crime
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting crimes in the hospital or clinics

Do Research.
We can use or share your information for health research.

Comply With The Law.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to Organ And Tissue Donation Requests
We can share information about you with organ procurement organizations such as Donor Alliance.

Work with A Medical Examiner Or Funeral Director.
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers' Compensation, Law Enforcement, and Other Government Requests.
We can use or share health information about you:

- For workers' compensation claims
- To your employer for:
  - a job related injury or illness;
  - workplace-related medical review; or
  - if your employer needs the record to follow the law.
- For law enforcement purposes or with a law enforcement official
- With the jail, prison, or police if you are an inmate or are in custody so they can take care of you and protect the health and safety of you, other inmates, and staff.
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond To Lawsuits And Legal Actions.
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Privacy Notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. Your request will be processed as soon as possible, but we may have already used or given out your records based on your prior authorization.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice.
We can change the terms of this Privacy Notice, and the changes will apply to all information we have about you. The new Privacy Notice will be available upon request, in all hospital and outpatient locations, and on our web site.