School Health Center Permission Form

Our school has a new health service available for all students, provided through Hazel Health. When your child feels sick at school, they can be seen by a health care provider over video, without leaving school. By completing this form, your child can access this service.

You can complete this form online at: **my.hazel.co/dpsk12**

Month / Day / Year

Child's First Name _____ Child's Last Name _____ Child's Birthdate ___/___/___

Parent / Guardian #1 Name _____ Mobile Phone ( ) _____ Home Phone ( ) _____

Parent / Guardian #2 Name _____ Mobile Phone ( ) _____ Home Phone ( ) _____

Is your child allergic to any medications?

☐ YES ☐ NO Please List: _____

Is your child currently taking any medications?

☐ YES ☐ NO Please List: _____

If recommended by a licensed medical provider, can the following medications (age/weight appropriate) be administered to your child at school? Mark YES or NO: ☒

YES	NO	
☐	☐	Tylenol™ / Acetaminophen (pain, fever)
☐	☐	Advil™ / Motrin™ / Ibuprofen (pain, fever)
☐	☐	Children's Pepto™ / Calcium Carbonate (upset stomach)
☐	☐	Liquid Pepto-Bismol™ / Bismuth Subsalicylate (nausea, indigestion, upset stomach)
☐	☐	Liquid Antacid / Aluminum Hydroxide / Magnesium Hydroxide, Simethicone (upset stomach)
☐	☐	Throat Lozenge / Benzocaine / Menthol (cough, sore throat)

YES	NO	
☐	☐	Cough Syrup / Dextromethorphan / Guaifenesin (cough)
☐	☐	Honey (cough)
☐	☐	Sudafed™ / Phenylephrine (congestion)
☐	☐	Hydrocortisone Cream (inflammation, itch)
☐	☐	Benadryl™ / Diphenhydramine (allergic reaction)
☐	☐	Zyrtec™ / Cetirizine (allergies, allergic reaction)
☐	☐	Zaditor™ / Ketotifen (allergy eye drops)
☐	☐	Antibiotic Ointment / Bacitracin / Neomycin / Polymyxin B (cuts, infections)

I have read the Hazel Health Services Authorization and Privacy Policy and: (Please check one box below)

☐ I **give** permission for my child to receive services from Hazel Health Services.

☐ I **DO NOT give** permission for my child to receive services from Hazel Health Services.

Parent / Guardian Signature (Required) _____ **Date** _____

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Child's First Name	Child's Last Name	Child's Birthdate (Month / Day / Year)
		/ /

Has your child ever had any of the following health conditions or health concerns?

Mark YES or NO: ☒

YES	NO		
☐	☐	Allergies, other than medications (food, seasonal)	List Allergies:
☐	☐	Asthma	Date of Last Attack:
☐	☐	Lung Problems	List Lung Problems:
☐	☐	Diabetes	
☐	☐	Heart Problems	Circle Problems: High Blood Pressure / Aortic Arch Obstruction — Other:
☐	☐	Acid Reflux (Heartburn)	
☐	☐	Infections	Circle Infections: Ears / Bladder / Throat — Other:
☐	☐	Seizures	Date of Last Seizure:
☐	☐	Anxiety	
☐	☐	Depression	
☐	☐	ADD / ADHD (Attention Deficit Hyperactivity Disorder)	
☐	☐	Surgery	Circle Surgeries: Appendix / Gallbladder / Tonsils / Ear Tubes — Other:
☐	☐	Eczema	
☐	☐	Other	Please Describe:

Does your child have a primary care doctor?

☐ YES ☐ NO

Child's Doctor	Phone	Fax

Does your child have medical insurance?

☐ YES ☐ NO

Insurance Provider / Plan Name	Member Id Number	Group Number (if applicable)

Policy Holder (if applicable)	Policy Holder Birthdate	Relationship to Student

Hazel Health Services School Health Center Authorization

Understanding that my child may need healthcare treatment or healthcare screenings during school hours at the school or after hours outside the school, I hereby authorize Hazel Health Services, and the School by and through the Hazel Health Services telehealth service, to administer such first aid or other medical examination and treatment as shall be deemed best under the circumstances, and I consent for my child to receive such treatment. I understand that Hazel Health Services may not always be available due to capacity or other reasons. I represent and warrant that I am an authorized legal representative of the child. I understand that the School will attempt to notify an authorized legal representative of the child in the event of an emergency requiring immediate medical care for my child and if the School is unable to notify an authorized legal representative of the child, it will have my child treated by a duly qualified medical practitioner. I authorize Hazel Health Services to contact and leave a voicemail and/or a text message, leaving protected health or personally identifiable information, such as a diagnosis, of me or my child, on the supplied phone number and contact phone numbers from the School. I also understand that the transmission of personal health and/or personally identifiable information may not be secure and may be illegally accessed by a third party. Any medical information provided to the School may be shared with Hazel Health and Hazel Health Services.

1. PURPOSE. The purpose of this form is to obtain your consent for your child to participate in a telehealth consultation. This consent will authorize medical information about the child, including personally-identifiable medical information, to be disclosed to your school District, Hazel Health and Hazel Health Services and medical professionals, administrative staff, and employees of Hazel Health and Hazel Health Services for the purposes of treatment by and through a telehealth consultation. This disclosure will also authorize the use of written or recorded information containing the child's personally-identifiable medical information, including recordings of any telemedicine encounter with the child, for training and informational purposes by employees of the School or Hazel Health or Hazel Health Services and the use of personally-identifiable information by Hazel Health for the development and improvement of software, hardware, and related tools designed to improve services provided by medical professionals, administrative staff, contractors and employees of Hazel Health and Hazel Health Services. This consent will also authorize the disclosure of information and records containing or related to the child's personally-identifiable medical information for the purposes of billing commercial and insured healthcare payors, state and/or federal healthcare payors, including but not limited to state Medicaid plans. The purpose of the disclosure is to obtain information and/or renumeration for reimbursable medical services.
2. Your child's ability to receive services outside of the school setting will not be impacted. You may withdraw this consent at any time. The withdrawal will not relieve any public agency of its responsibility to ensure that all required services are provided at no cost to you. You understand that you may choose your provider and you have no obligation to select Hazel Health or Hazel Health Services as a healthcare provider for your child. You or your child will have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to medical records.
3. NATURE OF TELEHEALTH CONSULTATION. During the telemedicine consultation, the following may occur:
   A. Details of your child's medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of a mobile application with real-time, interactive video, audio and telecommunications technology.

B. Physical examination and behavioral assessment of your child may take place via a remote medical practitioner through the mobile application. Not all conditions can be treated by a telehealth consultation. You may see an appropriately trained staff person or employee in-person immediately after the telemedicine service if an urgent need arises or you will be told ahead of time that this is not available.

C. Non-medical personnel including school staff, Hazel Health Services employees and/or translators may be present to aid with language and technical implementation of the consultation.

D. Video, audio and/or photo recordings may be taken of the consultation. You consent to the inclusion of this information in your child's medical record.

4. MEDICAL INFORMATION AND RECORDS. All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination, beyond the potential uses listed in this consent, of any patient-identifiable images or information from this telehealth interaction will not occur without your explicit consent except you authorize Hazel Health Services to disclose protected health information about my child to school designees, school nurses, physicians, Hazel Health or other health care providers and payors for treatment and billing purposes. You also authorize Hazel Health to maintain and save your child's medical records consistent with applicable laws and regulations.

5. CONFIDENTIALITY. Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telehealth consultation, and all existing confidentiality protections under federal law and Colorado state law apply to information disclosed during this telehealth consultation.

6. RIGHTS. You may withhold or withdraw consent to telehealth consultation without risk to your eligibility to participate in any program, to the disclosure of personally identifiable information to any state or federal agency or other third party, or to any other services at any time. You acknowledge that you have been advised of your right to receive a copy of this authorization as signatory to the authorization.

7. RISK, CONSEQUENCES AND BENEFITS. I am aware of any potential risk, consequences and benefits of telehealth. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above. I am choosing to enroll in Hazel Health Services and am not being forced to utilize this program.

Notice of Privacy Practices - Hazel Health Services Affiliated Covered Entity

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.

This Notice of Privacy Practices (the "Notice") describes how School Based Urgent Care Network d/b/a Hazel Health Services and the members of its Affiliated Covered Entity (collectively "we" or "our") may use and disclose your protected health information to carry out treatment, payment or business operations and for other purposes that are permitted or required by law. An Affiliated Covered Entity is a group of health care providers under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). The members of the Hazel Health Services Affiliated Covered Entity will share protected health information with each other for the treatment, payment, and health care operations of the Hazel Health Services Affiliated Covered Entity and as permitted by HIPAA and this Notice of Privacy Practices. For a complete list of the members of the Hazel Health Services Affiliated Covered Entity, please contact the Hazel Health Services Privacy Office.

"Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or condition, treatment or payment for health care services. This Notice also describes your rights to access and control your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by our health care providers, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support our business operations, to obtain payment for your care, and any other use authorized or required by law.

TREATMENT:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a health care provider to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you.

PAYMENT:

Your protected health information may be used to bill or obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services, such as: making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

HEALTH CARE OPERATIONS:

We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, improving quality of care, providing information about treatment alternatives or other health-related benefits and services, development or maintaining and supporting computer systems, legal services, and conducting audits and compliance programs, including fraud, waste and abuse investigations.

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

We may use or disclose your protected health information in the following situations without your authorization. These situations include the following uses and disclosures: as required by law; for public health purposes; for health care oversight purposes; for abuse or neglect reporting; pursuant to Food and Drug Administration requirements; in connection with legal proceedings; for law enforcement purposes; to coroners, funeral directors and organ donation agencies; for certain research purposes; for certain criminal activities; for certain military activity and national security purposes; for workers' compensation reporting; relating to certain inmate reporting; and other required uses and disclosures. Under the law, we must make certain disclosures to you upon your request, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). State laws may further restrict these disclosures.

This Notice was originally published and effective on October 21, 2019.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless permitted or required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. Your protected health information will not be used for fundraising. If you provide us with an authorization for certain uses and disclosures of your information, you may revoke such authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

You have the right to inspect and copy your protected health information.

You may request access to or an amendment of your protected health information.

You have the right to request a restriction on the use or disclosure of your protected health/personal information. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have the right to request an amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to our statement and we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures of your protected health information that we have made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes.

You have the right to obtain a paper copy of this Notice, upon request, even if you have previously requested its receipt electronically by e-mail.

REVISIONS TO THIS NOTICE:

We reserve the right to revise this Notice and to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted on our web site. You then have the right to object or withdraw as provided in this Notice.

BREACH OF HEALTH INFORMATION:

We will notify you if a reportable breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the protected health information involved and contact information for you to ask questions.

COMPLAINTS:

Complaints about this Notice or how we handle your protected health information should be directed to our HIPAA Privacy Officer. If you are not satisfied with the manner in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

We must follow the duties and privacy practices described in this Notice. We will maintain the privacy of your protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please contact us at (415) 424-4266 and ask to speak with our HIPAA Privacy Officer or e-mail at privacy@hazel.co.