

Dear Parents and Guardians:

I am excited to share that the Howard County Health Department and Howard County Public Schools have opened a school-based wellness center at Wilde Lake High School. The school-based wellness center is opened two half days a week when school is in session and offers the following health care services by appointment to **all students regardless of health insurance or family income:**

- Physical exams- annual, sport, camp, and college entry
- Diagnosis and treatment of acute illnesses and injuries- **Walk-in appointments maybe available**
- Management of chronic health problems, such as asthma
- Health education
- Referrals for services not provided in the school-based wellness center
- Health screenings – behavioral and reproductive health

The center's physicians and nurse practitioners provide health services only during the school day and do not replace your child's regular health provider. The center staff works with your child's provider to coordinate his or her care. With your permission, a copy of your child's visit will be sent to your child's regular provider. Your signed consent and completion of the attached packet is required for your student to be enrolled and receive services in the school-based wellness center except for services covered under the Maryland Minor Consent Laws.

The Wilde Lake High School-Based Wellness Center will only bill Medical Assistance and managed care providers. No co-pays or other fees will be collected.

Additional information can be provided and appointments made by contacting Sharon Hobson, the program administrator, at (410) 313-7238.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTER PROGRAM

Parent/ Guardian Secondary School Consent Form

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p>Last Name: _____</p> <p>First Name: _____</p> <p>Address: _____</p> <p style="text-align: center;">City State Zip Code</p> <p>Email: _____</p> <p>Cell Phone: _____</p> <p>Date of Birth: _____ / _____ / _____ Month Day Year</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-Binary _____</p> <p>Social Security Number (optional): _____</p> <p>Race / Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>Preferred Language: _____</p> <p>Name of School: _____</p> <p>Grade: _____</p>	<p><u>Parent/Legal Guardian</u></p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Contact Number(s): _____</p> <p>E-mail Address: _____</p> <p>Preferred Language: _____</p> <p>Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or Uncle <input type="checkbox"/> Other: _____</p> <p><u>Additional Emergency Contact</u></p> <p>Name: _____</p> <p>Relationship to Student: _____</p> <p>Contact Number(s): _____</p>

HEALTH INSURANCE INFORMATION

Does your child have Medical Assistance? No Yes Private Insurance? No Yes No Insurance? No Yes

If Medical Assistance, please provide the following information. Medical Assistance # _____ and
Patient ID # _____

Which health insurer does your child receive health services through? Please check the appropriate box below:
 AMERIGROUP Maryland Physicians Care Riverside Jai Medstar United Healthcare-Community Plan
 Kaiser Permanente Priority Partners

If your child does not have health insurance, would you like the Howard County Health Department staff contact and assist you with applying for health insurance? No Yes

**Please turn this page over, read, sign and date on the two designated lines.
Thank you!**



IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTER PROGRAM
Parental Consent Form For Secondary School-Based Wellness Centers

Child's Name: _____

School: _____

SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Howard County Health Department School Based Wellness Center. I further understand that under Maryland Minor Consent Laws, a minor (a person under the age of 18) has the same capacity as an adult to consent to receiving education and referral for: substance abuse, reproductive health, mental health issues (16 years or older), and the diagnosis and/or treatment of sexually transmitted diseases without parent/guardian notification or consent. Pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions.

School-Based Wellness Center services may include, but are not limited to:

- Health screening and comprehensive physical examinations (complete medical examination) including those for EPSDT, school and sports
- Medically prescribed, basic laboratory tests which may include venipuncture and testing of other body fluids, such as urine or throat and wound secretions, for conditions including anemia, sexually transmitted diseases, strep throat, and diabetes
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
- Referrals for services not provided at the school-based wellness center
- Annual health questionnaire/survey and health education and risk prevention counseling
- Appointments via telemedicine when in-person visits are not possible

x _____
Signature of Parent/Guardian

Date

HOWARD COUNTY HEALTH DEPARTMENT'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my child to release any medical or other information to assist in the management of my child's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information and that I can change my mind at any time and revoke my authorization by writing to the School-Based Wellness Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:

Information Required by Law or School System:

- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

Information to Protect Health and Safety:

- Conditions which may require emergency medical treatment
- Mental health conditions including evaluations, diagnosis, treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity
- Health insurance coverage

PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, voluntarily consent to treatment of my child by the provider and staff of the Howard County Health Department School Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I authorize payment directly to the HCHD for services for which HCHD accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

x _____
Signature of Parent/Guardian

Date

Time Period During Which Release of Information is Authorized:

From: Date that form is signed

To: Date that student is no longer enrolled in the School-Based Wellness Center

By checking this box, I am granting permission for my child to have a telemedicine visit even if the school nurse is unable to contact me at the time of the visit.

x _____
Signature of Parent/Guardian

Date

HOWARD COUNTY HEALTH DEPARTMENT SCHOOL-BASED WELLNESS CENTERS PROGRAM

Medical and Family History Questionnaire

Child's Name:	Today's Date:
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FAMILY HEALTH INFORMATION

Does any of the child's family members (parents, sisters, brothers, grandparents) have or had the following:

Health Problem	Yes	No	Which Family Member?
Asthma			
Diabetes			
Mental Health/ Psychiatric Problem			
Sickle Cell			
Other:			

Who is the student's regular health provider?

Name: _____ Office Telephone: _____

Address: _____

When was your child's last physical or well child exam? _____
Month/Year

Please provide the name and phone number of your pharmacy.

Name: _____ Phone Number: _____

CHILD'S HEALTH INFORMATION

Please place a check in the box for any health problems your child has had.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Infection (frequent)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Headache (frequent)
<input type="checkbox"/> Hearing	<input type="checkbox"/> Heart Problems/Murmur	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vision	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Allergies (List all, including medicines):			

If your child has been hospitalized, please provide the date(s) and reason(s):

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES: _____

MARYLAND DEPARTMENT OF HEALTH AND YOUR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES

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

Introduction

The Maryland Department of Health (MDH) is committed to protecting your health information. MDH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your health care, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. MDH and its Business Associates are required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any MDH agency. It is also posted on our website at <https://health.maryland.gov/pages/index.aspx>

Permitted Uses & Disclosures

MDH employees will only use your health information when doing their jobs. For uses beyond what MDH normally does, MDH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions. The following are some examples of our possible uses and disclosures of your health information:

Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:

- **For treatment:** MDH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, MDH health care providers may need to review your treatment with your health care provider for medical necessity or for coordination of care.
- **To obtain payment:** MDH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** MDH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures of Health Information Required or Permitted by Law:

- **Information purposes:** Unless you provide us with alternative instructions, MDH may send appointment reminders and other materials about the program to your home.
- **Required by law:** MDH may disclose health information when a law requires us to do so.
- **Public health activities:** MDH may disclose health information when MDH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.
- **Health oversight activities:** MDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** MDH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes:** In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, MDH may disclose health information to assist medical research.

- **Avert threat to the health or safety:** In order to avoid a serious and imminent threat to health or safety, MDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** MDH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. MDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** MDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **Family, friends, or others involved in your care:** MDH may share your health information with people as it is directly related to their involvement in your care or payment of your care. MDH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** MDH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** MDH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a MDH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, MDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** MDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** MDH may conduct the above-described activities ourselves, or we may use non-MDH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** MDH may use information about you to contact you in an effort to raise money for MDH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at MDH.

Your Rights

You Have a Right to:

- **Request restrictions:** You have the right to request a restriction or limitation on the health information MDH uses or discloses about you. MDH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, MDH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that MDH send you information at an alternative address or by alternative means. MDH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the PHI. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If MDH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that MDH correct or add to your health record. MDH will respond to your request within 60 days, with up to a 30-day extension, if needed. MDH may deny the request if MDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If MDH approves the request for amendment, MDH will change the

health information and inform you, and MDH will tell others that need to know about the change in the health information.

- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, MDH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year. Additionally, MDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to opt-out of a MDH facility's patient directory, and you have the right to opt-out of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System for our Patients (CRISP).
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information:** If any of MDH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, MDH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

For More information:

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact **Antigone Vickery, Deputy Health Officer, Howard County Health Department at 410-313-6300.**

To Report a Problem about our Privacy Practices:

If you believe that your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Maryland Department of Health, Division of Corporate Compliance at 1-866-770-7175.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. You may call the Maryland Department of Health for the contact information.

MDH will take no retaliatory action against you if you make such complaints.

Effective Date: This notice is effective on July 1, 2017.

(Provider programs must ensure that they try to get this acknowledgement signed)

Acknowledgement of receipt of this notice:

Patient or Authorized Representative

Date

If unable to get acknowledgement, specify why:

Signature of MDH representative