Dear Parent/ Legal Guardian,

Your child's high school is part of a special program that offers additional healthcare services to students on-site in the school clinic, including treatment of minor illnesses and injuries, lab tests, chronic disease management, and preventive care such as physicals and immunizations - all at NO COST to you.

For your child to receive this enhanced care from the medical provider on campus, you MUST submit the attached paperwork to the clinic:

Consent for School-Based Health Clinic Services – complete the entire form and sign *Section 3* and, if your student has Medicaid, check the box in *Section 4* and sign the bottom.

Adolescent Health History – complete the entire form.

Initiation of Services – complete and sign *Part VII.*

Interagency Consent for Services and Release of Information – complete and sign.

Notice of Privacy Practices – keep for your records.

Students who do not have written consent on file CANNOT be seen by the medical provider.

For more information, visit our web site at https://tinyurl.com/SchoolBasedClinics.

These expanded services are funded by the Juvenile Welfare Board (JWB) through local taxes. As part of the funding, the Florida Department of Health in Pinellas County is required to collect personally identifiable information on students for program accountability and quality improvement activities.

The School-Based Health Clinics Program is a partnership between the Florida Department of Health in Pinellas County, JWB, the Pinellas County School Board, Suncoast Center, Inc., and the administrations at Boca Ciega, Gibbs, Northeast, Largo and Pinellas Park high schools.

If you have any questions about these forms or services, please contact the clinic at your child's school:

Boca Ciega High School Clinic: (727) 893-2780 ext. 2026
Gibbs High School Clinic: (727) 893-5452 ext. 2026
Largo High School Clinic: (727) 588-3758 ext. 2026
Northeast High School Clinic: (727) 570-3138 ext. 2325
Pinellas Park High School Clinic: (727) 538-7410 ext. 2026

Florida Department of Health
in Pinellas County
205 Dr. Martin Luther King Jr. St. N. • St. Petersburg, FL 33701-3109
PHONE: (727) 824-6900 • FAX (727) 820-4285
FloridaHealth.gov

Querido Padre/Madre/Tutor/a Legal,

La escuela secundaria de su niño/niña es parte de un programa especial que ofrece cuidado médico adicional para los estudiantes en la clínica allí mismo, incluso tratamiento de enfermedades u heridos leves, pruebas de laboratorio, tratamiento de enfermedades crónicas, y cuidado preventivo tal como físicos y vacunas – todo SIN COSTO a ustedes.

Es REQUISITO que entregue las siguientes formas a la clínica para que el niño/la niña recibe los servicios médicos adicionales:

Consentimiento Para Servicios de Salud en la Escuela – completa la forma entera y firme parte 3, y si el niño/la niña tiene Medicaid, marque la caja en parte 4 y firme abajo.

Historial de Salud del Adolescente – completa la forma entera.

Inicio de Servicios – completa y firme *Parte VII.*

Consentimiento Inter-agencial Para Servicios y Autorización de Revelar Información – completa y firma.

Noticia de Practicas Privadas – se la puede guardar.

Los estudiantes que no entreguen las formas de consentimiento NO pueden recibir los servicios de salud adicionales y NO pueden ver al médico/a. Para más información, visite la página web a https://tinyurl.com/SchoolBasedClinics.

Los servicios médicos adicionales son financiados por el Juvenile Welfare Board (JWB) de impuestos locales. Como parte de este financiamiento, se requiere que el Florida Department of Health in Pinellas County obtenga información identificable de los estudiantes para rendir cuentas y hacer refinamiento de la calidad.

El programa de School-Based Health Clinics es una colaboración entre el Florida Department of Health in Pinellas County, JWB, el Pinellas County School Board, Suncoast Center, Inc., y las administraciones de las escuelas secundarias de Boca Ciega, Gibbs, Northeast, Largo and Pinellas Park.

Si surge una pregunta sobre las formas o los servicios, llame a la clínica de la escuela del niño/de la niña.:

Boca Ciega High School Clinic: (727) 893-2780 ext. 2026
Gibbs High School Clinic: (727) 893-5452 ext. 2026
Largo High School Clinic: (727) 588-3758 ext. 2026
Northeast High School Clinic: (727) 570-3138 ext. 2325
Pinellas Park High School Clinic: (727) 538-7410 ext. 2026

FLORIDA DEPARTMENT OF HEALTH

Consent for School-Based Health Clinic Services

1. Student information (please print clearly)

Last Name: _____ Date of Birth: _____

First Name: _____ School: _____

Middle Name: _____ Grade: _____

Suffix (Jr., Sr., II, III, etc.): _____ Social Security #: _____

2. Services Available to High School Students at NO Cost:

Please check any services we **cannot** provide to your child.

- ☐ School/Sports Physicals
- ☐ Immunizations
- ☐ Lab Tests (e.g. throat, urine cultures)
- ☐ Care For Minor Illness & Injuries
- ☐ Administer Over the Counter Medications (e.g. Tylenol, Ibuprofen, Tums)
- ☐ Social, Emotional, and Mental Health Counseling

Comments:

3. Agreement for Student Services

Please read carefully and sign:

I do hereby give my consent for the above named student to receive services at the Florida Department of Health School-Based Clinic. All services listed above that have not been checked will be available to my child. I further understand that all services authorized by myself will be available at no cost.

Please check one: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

The Following Questions are for Data Gathering Purposes Only

1. Is your child covered by Private Insurance? ☐ Yes ☐ No
2. Is your child covered by Healthy Kids? ☐ Yes ☐ No
3. I am aware of Florida Kid Care program and I know how to apply for it. ☐ Yes ☐ No*

*If you answered **no** to question #3, contact Florida KidCare at 1-888-540-5437 Monday – Friday, 7:30 am – 7:30 pm (ET).

4. Medicaid Coverage Consent

Is your child covered by Medicaid? ☐ Yes ☐ No (If Yes, please continue. If No, please skip the rest of Section 4 below.)

State of Florida Consent for Billing Medicaid

Although all school-based clinic services are available at no cost to you, the Florida Department of Health does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

I hereby assign the Florida Department of Health all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health. I further authorize the Florida Department of Health at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Select One: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

DEPARTAMENTO DE SALUD DEL ESTADO DE FLORIDA

Permiso para clínicas de salud en la escuela

1. Información del estudiante (por favor, escriba claramente)

Apellido: _____ Fecha de nacimiento: _____

Nombre: _____ Escuela: _____

Segundo nombre: _____ Grado: _____

Sufijo (Jr., Sr., II, III, etc.): _____ Seguro social #: _____

2. Servicios disponibles sin costo para la escuela secundaria:

Por favor, marque los servicios que no podemos proveerle a su hijo:

- ☐ Exámenes físicos escolares/deportivos
- ☐ Vacunas
- ☐ Exámenes de laboratorio (p. ej. cultivos de garganta y de orina)
- ☐ Cuidados de enfermedades y lesiones menores
- ☐ Administración de medicamentos de venta libre (e.g. Tylenol, Ibuprofeno, Tums)
- ☐ Consejería social, emocional y de salud mental

Comentarios:

3. Acuerdo para servicios a los estudiantes

Por favor, lea cuidadosamente y firme:

Por medio de la presente doy mi consentimiento para que el estudiante mencionado anteriormente reciba servicios en la Clínica Escolar del Departamento de Salud de Florida. Todos los servicios enumerados anteriormente, que no hayan sido marcados, estarán disponibles para mi hijo. Además, entiendo que todos los servicios autorizados por mí estarán disponibles sin costo alguno.

Por favor, marque uno: ☐ **Padre** ☐ **Guardián legal** ☐ **Estudiante (si tiene 18 años o más)**

Nombre (letra de imprenta): _____ Firma: _____ Fecha: _____

Las siguientes preguntas son para recopilación de datos solamente

1. ¿Está su hijo cubierto por un seguro privado? ☐ Sí ☐ No
2. ¿Está su hijo cubierto por Healthy Kids? ☐ Sí ☐ No
3. Conozco el programa Florida Kid Care y sé cómo solicitarlo. ☐ Sí ☐ No*

*Si contestó **no** a la pregunta #3, comuníquese con Florida Kid Care al 1-888-540-5437 Lunes – Viernes, 7:30 am – 7:30 pm (hora del Este).

4. Permiso para cobertura de Medicaid

¿Está su hijo cubierto por Medicaid? ☐ Sí ☐ No (En caso afirmativo, continúe. En caso negativo, omita el resto de la Sección 4 a continuación)

Permiso del Estado de Florida para facturar a Medicaid

A pesar de que todos los servicios de clínicas escolares están disponibles sin costo alguno para usted, el Departamento de Salud de Florida recibe asistencia financiera parcial al facturar a Medicaid por estudiantes con cobertura de Medicaid. Si su hijo está cubierto por Medicaid, firme el siguiente consentimiento.

Por medio de la presente asigno al Departamento de Salud de Florida todos los beneficios provistos bajo el plan de atención médica de Medicaid. El monto de tales beneficios no deberá exceder los cargos médicos establecidos por la Junta de Comisionados del Condado de Pinellas. Todos los pagos contemplados en este párrafo deben hacerse al Departamento de Salud de Florida. También autorizo al Departamento de Salud de Florida, ubicado en 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701, y a cualquier médico o proveedor de atención médica que examine o trate a mi hijo, a divulgar a un tercero cualquier información médica, psiquiátrica/psicológica, abuso de alcohol/drogas, enfermedades de transmisión sexual, tuberculosis, SIDA, VIH, abuso o información de administración de casos, incluyendo la información recibida de otros proveedores de atención médica con respecto al diagnóstico y tratamiento, para poder determinar un reclamo por dicho diagnóstico o tratamiento. Esto puede incluir parte o toda la información relacionada con los pagos.

Seleccione uno: ☐ **Padre** ☐ **Guardián legal** ☐ **Estudiante (si tiene 18 años o más)**

Nombre (letra de imprenta): _____ Firma: _____ Fecha: _____

Adolescent Health History
Confidential

Name: _____ _____ _____ **Date:** _____
Last **First** **Middle**

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **Twin:** ☐ **Yes** ☐ **No**

Ethnicity: ☐ **Hispanic: Country of origin** _____
☐ **Non-Hispanic**

Race: _____

Primary language spoken: _____
Number of Minor Children in home: _____
Number of Adults in home: _____
Household income (before taxes): $_____

Household Arrangement (select one):
___ **Single Parent: Female Head of household**
___ **Single Parent: Male Head of household**
___ **Dual Parent (both parents): Married**
___ **Dual Parent: Non-Married Male/Female**
___ **Other** _____

Medical History

Does your child have a primary care doctor? Yes No Name of Personal/ Family doctor:_____ Date of last visit with doctor: ___/___/___ Date of last physical: ___/___/___	Does your child have allergies? Yes No Allergic Reaction(s): _____ Does your child carry epi pen or inhaler? Yes No
Does your child have a dentist? Yes No Date of last dental exam: ___/___/___	Is your child taking any medications? Yes No Please list medication, dose, and frequency:

Please answer all questions below. For responses with Yes, indicate the age diagnosed and describe below:

		Yes	No	Age			Yes	No	Age			Yes	No	Age
1	ADHD	☐	☐		17	Mononucleosis	☐	☐		33	Victim of physical or sexual abuse	☐	☐	
2	Anemia or bleeding disorders	☐	☐		18	Nosebleeds	☐	☐		**Family History**			Relationship	
3	Asthma	☐	☐		19	Pneumonia	☐	☐		1	ADHD	☐	☐	
4	Autism spectrum	☐	☐		20	Prediabetes	☐	☐		2	Asthma	☐	☐	
5	Cancer	☐	☐		21	Premature birth	☐	☐		3	Cancer	☐	☐	
6	Dental problems/cavities	☐	☐		22	Scoliosis/orthopedic problems	☐	☐		4	Depression	☐	☐	
7	Diabetes Type 1 or 2	☐	☐		23	Seizures	☐	☐		5	Diabetes	☐	☐	
8	Eating disorder or concerns	☐	☐		24	Severe acne/skin problem	☐	☐		6	Heart Disease	☐	☐	
9	Fainting spells	☐	☐		25	Severe menstrual cramps	☐	☐		7	High Blood Pressure	☐	☐	
10	Headaches or Migraines	☐	☐		26	Sickle cell disease	☐	☐		8	High Cholesterol	☐	☐	
11	High blood pressure or heart disease	☐	☐		27	Single kidney	☐	☐		9	Kidney Disease	☐	☐	
12	High cholesterol	☐	☐		28	School academic or social concerns	☐	☐		10	Does anyone smoke in the house?	☐	☐	
13	Hospitalizations	☐	☐		29	Snoring or sleep problem	☐	☐		11	If either biological parent is deceased if yes, cause:	☐	☐	
14	Kidney or bladder problems	☐	☐		30	Stomach problems	☐	☐		12	Other:	☐	☐	
15	Menstrual irregularities	☐	☐		31	Surgeries	☐	☐		13	Other:	☐	☐	
16	Mental Health	☐	☐		32	Testes	☐	☐		14	Other:	☐	☐	

If answered Yes above, please describe:

Historial de Salud del Adolescente
Confidencial

Nombre: _____ _____ _____ **Fecha:** _____
Apellido **Nombre** **Segundo nombre**

Fecha de nacimiento: _____/_____/_____ **Edad:** _____ **Sexo:** ☐ **M** ☐ **F** **Gemelo /mellizo:** ☐ **Sí** ☐ **No**

Etnia: ☐ **Hispano: País de origen** _____
☐ **No Hispano**

Raza: _____

Arreglo familiar (seleccione uno):
___ **Padre soltero: Madre cabeza de familia**
___ **Padre soltero: Padre cabeza de familia**
___ **Padre doble (ambos padres): Casados**
___ **Padre doble: No Casado Padre/Madre**
___ **Otro** _____

Idioma principal: _____
Número de niños menores en el hogar: _____
Número de adultos en el hogar: _____
Ingresos del hogar (antes de los impuestos): $_____

Historia Médica

¿Tiene su hijo un médico de atención primaria? Sí No
Nombre del doctor personal/ familiar: _____
Fecha de la última visita médica ___/___/___
Fecha del último examen físico: ___/___/___

¿Sufre su hijo de alergias? Sí No
Reacciones alérgicas: _____
¿Carga su hijo un *epi pen* o un inhalador? Sí No

¿Tiene su hijo un dentista? Sí No
Fecha del último examen dental: ___/___/___

¿Está su hijo tomando algún medicamento? Sí No
Por favor, especifique el medicamento, el dosis, y la frecuencia:

Responda todas las preguntas a continuación. Para respuestas con *Sí*, indique la edad del diagnóstico y describa a continuación:

		Sí	No	Edad			Sí	No	Edad			Sí	No	Edad
1	TDAH	☐	☐		17	Mononucleosis	☐	☐		33	Víctima de abuso físico o sexual	☐	☐	
2	Anemia o trastornos hemorrágicos	☐	☐		18	Hemorragias nasales	☐	☐		**Historia familiar**				Relación
3	Asma	☐	☐		19	Neumonía	☐	☐		1	TDAH	☐	☐	
4	Espectro autista	☐	☐		20	Prediabetes	☐	☐		2	Asma	☐	☐	
5	Cáncer	☐	☐		21	Nacimiento prematuro	☐	☐		3	Cáncer	☐	☐	
6	Problemas dentales/caries	☐	☐		22	Escoliosis/problemas ortopédicos	☐	☐		4	Depresión	☐	☐	
7	Diabetes Tipo 1 or 2	☐	☐		23	Convulsiones	☐	☐		5	Diabetes	☐	☐	
8	Trastorno alimenticio o preocupaciones	☐	☐		24	Acné severo/problemas de la piel	☐	☐		6	Cardiopatía	☐	☐	
9	Desmayos	☐	☐		25	Cólicos menstruales severos	☐	☐		7	Presión arterial alta	☐	☐	
10	Dolores de cabeza o migraña	☐	☐		26	Anemia drepanocítica	☐	☐		8	Colesterol alto	☐	☐	
11	Presión arterial alta o cardiopatía	☐	☐		27	Riñón único	☐	☐		9	Enfermedad del riñón	☐	☐	
12	Colesterol alto	☐	☐		28	Preocupaciones escolares sociales o académicas	☐	☐		10	Alguien fuma en la casa	☐	☐	
13	Hospitalizaciones	☐	☐		29	Ronca o tiene problemas para dormir	☐	☐		11	Si un padre biológico ha fallecido, nota la causa:	☐	☐	
14	Problemas del riñón o la vejiga	☐	☐		30	Problemas estomacales	☐	☐		12	Otro:	☐	☐	
15	Irregularidades menstruales	☐	☐		31	Cirugías	☐	☐		13	Otro:	☐	☐	
16	Salud Mental	☐	☐		32	Testículos	☐	☐		14	Otro:	☐	☐	

Si respondió sí a alguna pregunta, por favor, describa:

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: Florida Department of Health in Pinellas County

Agency Address: 205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

N/A By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

INICIO DE LOS SERVICIOS

PARTE I **CONSENTIMIENTO PARA EL INICIO DE LA RELACIÓN ENTRE CLIENTE Y PROVEEDOR**

Nombre del cliente: _____

Nombre de la Agencia: Florida Department of Health in Pinellas County

Dirección de la Agencia: 205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701

Doy mi consentimiento para iniciar la relación entre cliente y proveedor. Autorizo al personal del Departamento de Salud (Department of Health) y a sus representantes a proporcionar la atención médica de rutina. Entiendo que la atención médica de rutina es confidencial y voluntaria, y puede implicar consultas médicas, incluyendo, obtención de mi historia médica, evaluaciones, exámenes médicos, administración de medicamentos o análisis de laboratorio o procedimientos menores. Puedo terminar con esta relación en cualquier momento.

N/A Al poner mis iniciales en este renglón, reconozco que he recibido una Hoja informativa de consentimiento informado sobre telesalud y que doy mi consentimiento para que se ofrezcan algunos servicios a través de telesalud. Puedo revocar mi consentimiento en cualquier momento, lo que discontinuará el uso de los servicios de telesalud sin afectar mi derecho a la atención o al tratamiento futuros.

PARTE II **CONSENTIMIENTO PARA REVELAR INFORMACIÓN** (Solo para propósitos de tratamiento, pago u operaciones de atención médica).

Para fines de tratamiento, pago u operaciones de atención médica, doy mi consentimiento para que se use y se revele mi información de salud, incluyendo información médica, dental, sobre VIH/SIDA, ETS, TB y prevención de trastornos por abuso de sustancias, información psiquiátrica/psicológica y de administración de casos. Además, doy mi consentimiento para que mi información médica se comparta en el Health Information Exchange (intercambio de información médica, HIE), lo que permite el acceso a los consultorios médicos, hospitales, coordinadores de atención, laboratorios, centros de radiología y otros proveedores de atención médica participantes a través de medios electrónicos seguros. Si elige no compartir su información en el HIE, puede optar por no participar si pide y firma un formulario de exclusión del HIE.

PARTE III **CERTIFICACIÓN, AUTORIZACIÓN PARA REVELAR Y SOLICITUD DE PAGO DEL PACIENTE DE MEDICARE** (Solo aplica a clientes de Medicare).

Yo, el cliente/representante que firma abajo, certifico que la información que di en la solicitud de pago según el Título XVIII de la Ley de Seguro Social es correcta. Autorizo a la agencia de arriba a revelar mi información médica a la Administración del Seguro Social o sus intermediarios/aseguradoras para este u otros reclamos relacionados con Medicare. Solicito que se paguen los beneficios autorizados en mi nombre. Cedo los beneficios pagaderos por servicios médicos a la agencia mencionada arriba y la autorizo a presentar el reclamo ante Medicare para el pago.

PARTE IV **CESIÓN DE LOS BENEFICIOS** (Solo aplica a pagadores externos).

Yo, el cliente/representante que firma abajo, cedo a la agencia mencionada arriba todos los beneficios que reciba de cualquier plan de atención médica o póliza de gastos médicos. La cantidad de esos beneficios no debe superar los cargos médicos establecidos en la lista de tarifas aprobadas. Todos los pagos cubiertos en este párrafo deben hacerse a la agencia indicada arriba. Entiendo que soy personalmente responsable de los gastos que no cubra esta cesión.

PARTE V **OBTENCIÓN, USO O REVELACIÓN DEL NÚMERO DEL SEGURO SOCIAL**

(Este aviso se entrega según la Sección 119.071(5)(a) de los Estatutos de Florida).

Para los programas de atención médica, el Departamento de Salud de Florida puede recopilar su número del Seguro Social con fines de identificación y facturación, según se autoriza en las subsecciones 119.071(5)(a)2.a y 119.071(5)(a)6 de los Estatutos de Florida. Firmando abajo, doy mi consentimiento para que se recopile, use o revele mi número del Seguro Social únicamente con fines de identificación y facturación. No podrá usarse con ningún otro fin. Entiendo que el Departamento de Salud de Florida debe recopilar los números del Seguro Social para cumplir las obligaciones y las responsabilidades que exige la ley.

PARTE VI **SI FIRMO ABAJO, CERTIFICO QUE LA INFORMACIÓN DE ARRIBA ES CORRECTA Y CONFIRMO QUE RECIBÍ EL AVISO DE LOS DERECHOS DE PRIVACIDAD**

Firma del cliente o su representante	Relación propia o del representante con el cliente	Fecha
Testigo (opcional)	Fecha	

PARTE VII **REVOCACIÓN DEL CONSENTIMIENTO**

Yo, _____ REVOCO ESTE CONSENTIMIENTO, vigente a partir del _____

Firma del cliente o su representante Fecha

INTERAGENCY CONSENT
FOR SERVICES AND RELEASE OF INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ Apartment/Unit/Lot: _____

City: _____ Zip Code: _____ Telephone Number: _____

School: ☐ Boca Ciega, Northeast, Gibbs, Pinellas Park, Largo HS ☐ Other School: _____

Check the appropriate box then read and sign the Consent Section:

☐ As the parent/legal guardian of the above-named student, I, _____, consent to the student receiving services from the *Florida Department of Health in Pinellas County* and *Suncoast Center, Inc.*

☐ I, the above-named adult or legally emancipated student, consent and agree to receive services from the *Florida Department of Health in Pinellas County* and *Suncoast Center, Inc.*

The expanded services at the school are funded by the Juvenile Welfare Board (JWB) through local taxes. As part of the funding, the *Florida Department of Health in Pinellas* and *Suncoast Center, Inc.* are required to collect additional personally identifiable information on the student for program accountability and quality improvement activities. However, the student will not be denied the basic school health services if you choose not to sign the form.

Consent Section

I consent to myself or my minor participating in online or paper surveys that will be used for program improvements and enhancements.

I authorize the *Florida Department of Health in Pinellas County and Suncoast Center, Inc.* to release to and receive from the *School Board of Pinellas County* medical/education records (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

I authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.*, and *School Board of Pinellas County* to release personally identifiable student information, such as student social security number, name, address, date of birth, household number, household living arrangement (parents, single parent, grandparent etc.), and free and reduced lunch information to JWB.

I also authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.,* and *School Board of Pinellas County* to release protected health information and all information pertaining to treatment received at the school clinic, home or anywhere else where I am receiving treatment from these providers and any and all other medical information in their control to JWB. I further authorize the *Florida Department of Health in Pinellas County*, *Suncoast Center, Inc.,* and *School Board of Pinellas County* to release records which may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention to JWB.

I understand that the Records will be released and received for the purpose of treatment, payment/reimbursement, quality improvement and research activities. I understand that any information disclosed, received or used by JWB based on this consent will not be further disclosed to any other party without my express written consent or as otherwise permitted or required by applicable law. However, the individually identifiable information received by JWB based on this consent may be used by JWB and its agents for research purposes, so long as the research results are reported as a whole in de-identified format, which means that no information that identifies an individual is revealed. Except, JWB will not provide any records covered by CFR Title 42 to any JWB agents.

I understand this consent is in place while the above named student is enrolled in one of the above named Pinellas County Schools. This consent will terminate when the above named student is no longer enrolled in or graduates from one of the above named Pinellas County Schools, except for the purpose of research and compliance reviews. I understand I have the right to revoke this consent at any time. If I revoke this consent, it must be in writing and be presented to the health clinic at the above named school. I understand that if I revoke my consent that it will not apply to any information already released and/or used as a result of my prior consent.

I release the School Board of Pinellas County, Florida Department of Health in Pinellas County, Suncoast Center, Inc., and the Juvenile Welfare Board of Pinellas County, their officers, agents, and employees, from liability for the release of information in accordance with this consent.

_____ _____ _____

Signature of parent/guardian or adult student (over 18 years old) Date Relationship to Student

_____ _____

Signature of Witness Date

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 IT CAREFULLY.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request.to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

PARTICIPATION IN THE HEALTH IFORMATION EXCHANGE NETWORK

Access to information about your health history and medical care is critical to help ensure that you receive high-quality care and gives your healthcare provider a more complete picture of your overall health. This can help your provider make better decisions about your care. The

information may also prevent you from having repeat tests, saving you time, money and worry. Recent advancements in technology now support the safe and secure electronic exchange of important clinical information from one health care provider to another through Health Information Exchange (HIE) networks. The Department of Health and its County Health Departments participate in an HIE network, and also participate in several HIE networks with trusted outside health care providers who have electronic medical record systems. HIE enables your healthcare providers to quickly and securely share your health information electronically among a network of healthcare providers, including physicians, hospitals, laboratories and pharmacies. Your health information is transmitted securely and only authorized healthcare providers with a valid reason may access your information. By sharing information electronically through a secure system, the risk that your paper or faxed records will be misused or misplaced is reduced.

Participation in HIE is completely your choice.

Choice 1. YES to HIE participation. If you agree to have your medical information shared through HIE and you have a current Initiation of Services and consent to treatment form on file, you do not need to do anything. By signing the form, you have granted us permission to share your health information to HIE.

Choice 2. NO to HIE. You can choose to not have your information shared electronically through the HIE network ("opt out") at any time, by filling out the "Health Information Exchange Opt-Out" form available at the County Health Department. If you decide to opt-out of HIE, healthcare providers will not be able to access your health information through HIE. You should understand that if you opt out, the health care providers treating you are still permitted to contact us to ask that your health information be shared with them as stated in this Notice. Opting out does not prevent information from being shared between members of your care team. Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out.

Choice 3: You can change your mind at any time.
You may consent today to the sharing of your information via HIE and change your mind later by following the instructions on the opt-out form described under Choice 2.

Alternatively, you may opt out of HIE today and change your mind later by submitting DOH HIE Reinstatement of Participation Form.

PERSONAL HEALTH RECORDS (PHR) MOBILE APPPLICATION SYNCHRONIZATION WITH USER DATA

As part of the services provided by the Department of Health, you can download the companion PHR mobile application to access your personal health records. This application is the mobile version of Florida Health Connect portal.

The purpose of the PHR mobile application is to provide you with access to your health data from your mobile device, from anywhere at any time. You will be able to synchronize your Florida Health Connect account through the mobile application with your personal health data captured on your mobile device (Google Fit or Apple Health) to provide you with a 360 degree view of your health history and current health status. In order to provide you with a complete

view of your health data and status, you will be provided with the option to synchronize your Florida Health Connect mobile application with the Google Fit or Apple Health application installed on your mobile device.

Your Google Fit or Apple Health data will not be disclosed to any third parties without your express written permission.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning February 21, 2022 and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).
HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).