Consent for Health Care Services and
Authorization to Release Student Information

Clinic: Webb City School Student Based Health Clinic (SBHC)
SBHC Contact: _____

Name of Student: _____
Current Grade: _____
School: _____

Address: _____
Home Phone: _____
Date of Birth: _____

Clinic Description. The SBHC located at Webb City High School, is a Mercy Health (Mercy) clinic intended to provide health care services to students, faculty, daycare children, and other employees attending the school district and to the immediate family members of students, faculty, daycare children and other employees attending the school district. The SBHC team includes a district employed nurse, and a Mercy employed nurse practitioner or physician assistant

Telemedicine Services. Telemedicine involves the use of audio, video or other electronic communications to interact with students for the purpose of diagnosis, therapy, follow-up and/or education. During telemedicine consultation, details of student's medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of a student may take place and video, audio, and/or photo recordings may be taken. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of the student's school. The SBHC located at Webb City High School may arrange a telemedicine consult for students located outside of Webb City School in order to assess or diagnose a student's condition and recommend treatment. All existing confidentiality protections under federal and Missouri law apply to information used or disclosed during your telemedicine consultation at any time before and/or during the consult without affecting your child's right to future care.

Consent for Services. As the parent and/or legal guardian, I hereby give my consent for the above named child to receive services offered by Mercy at the SBHC under the following term and conditions:

1. I understand that the services provided at the SBHC are routine health care services, as well as mental and behavioral health services, and that the clinic will provide comprehensive care for the school district.

2. I DO NOT want my child to receive the following services at the SBHC:

   _____

   _____

Student Name: _____ **Date of Birth:** _____

3. I authorize the SBHC to share information regarding treatment of the above named child to medical providers for any reason in accordance with medical practice and what is legally allowed by state and federal law.
4. I understand that this consent is valid during the time of my child's active enrollment as a student at Webb City School District. It will automatically terminate if/when my child graduates or is no longer an enrolled student. In addition, I can cancel this authorization at any time upon written notice.

   I understand that Missouri State law permits the provision of the following services to a minor with or without parental consent:

   - Diagnosis and treatment of sexually transmitted diseases
   - Pregnancy diagnosis and treatment
   - Drug and substance abuse treatment
   - Abuse and/or neglect

Insurance Information. For staff and students with private health insurance or who are eligible for Medicare or Medicaid, the SBHC is permitted to charge for the cost of services.

Medicaid/Medicare No. _____

Other Health Insurance _____

Name of Insured _____ Relation to Student _____

SSN of Insured (for Medicaid/Medicare) _____

Type of Coverage: Family: _____ Individual _____

I have read and understand the rights and conditions above and give consent for services as described herein.

Student's Signature _____ Date _____

_____ Relation to Student _____
Name of Parent/Legal Guardian

_____ Date _____
Signature of Parent/Legal Guardian

Student Name: _____ **Date of Birth:** _____

Release of Information. In order to obtain information necessary to monitor the effectiveness of the SBHC, your permission is requested by Mercy as follows:

If you give your permission by marking yes and initialing below, Mercy may obtain demographic, attendance and grade information from the school the student attends so that Mercy can measure program effectiveness. By initialing this box:

- You authorize Webb City School to release, demographic, attendance and grade information contained in its files with respect to the student named above.
- You understand that you can revoke this authorization at any time (in writing, except to the extent that action has already been taken in reliance on it.)
- **YOU UNDERSTAND THAT**
  - **THE RECORDS THAT CAN BE RELEASED MAY INCLUDE RECORDS WHICH ARE CONFIDENTIAL UNDER THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT, AND**
  - **THAT YOU KNOW YOU HAVE A RIGHT UNDER THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT TO REQUEST IN WRITING TO VIEW ANY EDUCATIONAL RECORDS RELEASED PURSUANT TO THIS AUTHORIZATION.**

YES: _____ NO: _____ Initials: _____

Confidentiality. Use and disclosure of a student's education records is protected under Federal and State law. Shared records protected by Federal and State law cannot be redisclosed.

Time Limit. Use and disclosure of any education records of the student is limited in time to the student's active enrollment as a student at Webb City School plus twelve (12) months. Upon twelve (12) months following transfer, graduation, or any other termination of active enrollment, this Authorization will automatically terminate. In addition, this authorization can be cancelled at any time upon written notice.

Scope of Use and Disclosure. Use and disclosure of any education records of the student will be limited in scope to the parties identified above except as required by law (including required reports to authorities to prevent serious harm to the student or others) or if Mercy is forced to disclose subject to a court-ordered subpoena. If Mercy reports any findings relating to the SBHC program in scientific journals, meetings, or the like, all data will be aggregate and no student names will be used or identifiable in the reports.

By signing this form, you give permission as described above for the use and disclosure of education records of the student listed below.

Student Name:	
Address:	
Date of Birth:	
SSN:	
Telephone:	
Current Grade Level:	

Signature of Student or Authorized Representative: _____

Student Name: _____ **Date of Birth:** _____

I understand that I do not have to sign this authorization. Mercy will not deny eligibility for services if I do not sign this form. I can inspect the protected health and education information to be used or disclosed. I authorize Webb City School to release to Mercy the demographic, attendance and grade information contained in the student's education records.

Signature: _____

Date: _____

Relation to Student: _____

Student Name: _____ **Date of Birth:** _____