Agreement for Exchange of Information

Patient (full legal name) _____ **DOB** _____

We provide healthcare as a team of parents/guardians, doctors, nurses, dentists and educators. We also want to protect student and family confidentiality to comply with the Privacy Act of 1974. If you sign this form, you give permission for the individuals/agencies below to discuss your child's needs and share physical and mental health information. If you have any questions or comments, please call the Clinic Coordinator at (319)631-3204.

I give permission for the agencies listed below to exchange written and verbal information with Healthy Kids School-Based Health Clinics and amongst themselves regarding my child for the purpose of medical and dental care:

☐ **Your child's SCHOOL**		
☐ **Johnson County Public Health**	Phone 319-356-6040	Fax 319-339-6176
☐ **College of Dentistry**	Phone 319-335-7499	Fax 319-335-8338
☐ **Free Medical Clinic of Iowa City**	Phone 319-351-2110	Fax 319-664-3636
☐ **Other** _____		

Release Information to: **Healthy Kids School-based Health Clinics**
Phone: 319-631-3204 Fax: 319-688-1009 Address: 1725 N. Dodge St. Iowa City, IA 52245

Information to send: _____

(A copy of this form is considered as valid as the original. The contact person will send copies of this form to all individuals/agencies listed below. Individuals/agencies listed are responsible for providing information requested.)

I understand that Healthy Kids School Clinics staff can direct me to the shared information upon request. I have the right to review information sent to ICCSD Healthy Kids School-Based Health Clinics and the right to revoke consent at any time. Shared records are protected by Federal and State law and cannot be disclosed.

Before giving your permission for exchange of information, please carefully review the following:
This authorization is good until your child reaches the age of 18 or until revoked, whichever occurs first. You may revoke this authorization, in writing, at any time; however, this does not affect information shared prior to your request for revocation.

Health Insurance Portability and Accountability Act (HIPAA)/
Family Educational Rights and Privacy Act (FERPA) Notice

Any and all personally identifiable information regarding children and families receiving Special Education services funded under the Individuals with disabilities Education Act is protected from unauthorized disclosure under FERPA. Personally identifiable information protected by FERPA is specifically **exempted** from HIPAA privacy standards. FERPA prohibits disclosure of personally identifiable information without parent consent except in limited circumstances, requires notice to be provided to the child's family regarding their privacy rights, requires providers to keep records of access to a child's records, and contains complaint and appeal procedures which apply to disputes over records in possession of Special Education or its providers, among other provisions. All Special Education providers comply with these procedures.

Notice to Recipients of Mental Health Information

In accordance with the Iowa Mental Health Information Disclosure Act (Iowa Code, Chapter 228), a recipient of mental health information may disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in chapter 228 and 220. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of Substance Abuse Information

This information has been disclosed from records whose confidentiality is protected by Federal law. Iowa Code, Chapter 125 and Federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

X _____ Date_____
Parent/Guardian Signature

Healthcare Consent Form

A student **must** have a consent form signed before being treated at **ICCSD Healthy Kids School-based Health Clinics** and **Johnson County Public Health**. Please complete the following information, **sign the form where indicated (X) and return to the clinic.**

Patient Name_____ School_____ Date of Birth_____

Address_____ Phone _____

Parent / Guardian Name _____ Parent Date of Birth _____

E-mail Address_____

CONSENT FOR CARE

I give consent for my child to receive health services from the ICCSD Healthy Kids School-Based Health Clinics and Johnson County Public Health, including over the counter medications. Permission for my child to receive services shall remain in effect until my child is 18 years of age unless revoked in writing by a parent or guardian. If I have requested that my child receive a routine or sports physical, I understand that an age-appropriate physical exam will be offered as part of our comprehensive services. I understand that all information about my child is confidential and will be treated in accordance with acceptable medical practice and the federal and state laws regarding privacy.

X SIGNATURE _____Date _____

I give consent for Healthy Kids School-Based Health Clinics staff to give vaccines to my child:

Give vaccines to my child: ◯YES ◯NO Give my child a seasonal flu shot or flu mist: ◯YES ◯NO

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REMINDERS

I consent to receive notifications of appointments and other non-medical information from the ICCSD Healthy Kids School-Based Health Clinics via telephone message or text message at the number indicated above. This consent is valid until the patient is 18 years of age unless revoked in writing.

X SIGNATURE _____ Date _____

TRANSPORTATION

I give my consent for ICCSD staff to provide transportation for my child, as needed for his/her healthcare, or when I am unavailable.

X SIGNATURE _____ Date_____