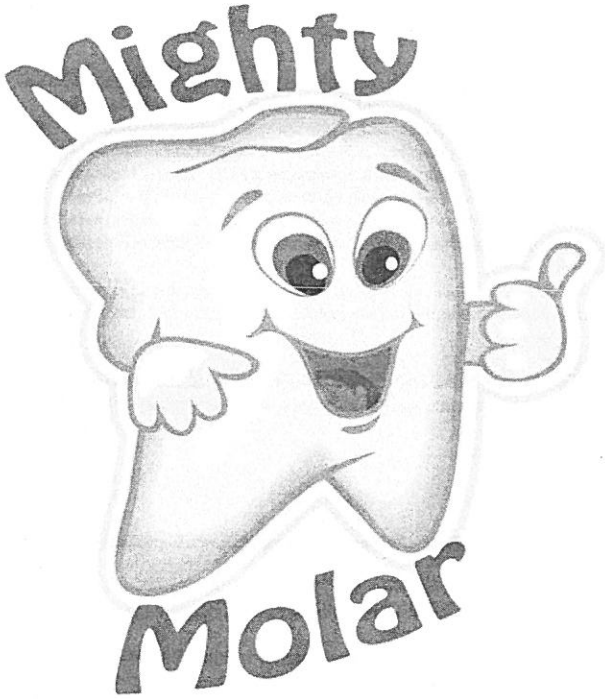
* ATTENTION PARENTS *

Has your child been to the dentist in the past year?

Do they have a local dentist that they visit regularly?

If you answered no, would you like them to receive services from BRDHD's Mighty Molar team at their school?



Only children with signed consent forms will be seen!

Medicaid will be billed for those students who are covered. All other students will be charged a $12 fee.

Barren River
DISTRICT HEALTH DEPARTMENT

Barren River
DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan,
Metcalfe, Simpson, and Warren Counties

Barren River District Health Department Privacy Notice
Effective September 23, 2013

PLEASE READ CAREFULLY:

This privacy is required by the ***Health Insurance Portability and Accountability Act (HIPAA)*** of 1996.

The privacy of your medical information is very important to us at the **Barren River District Health Department**. We need this record to provide you with quality and efficient health care.

This notice provides you with information on how your medical information may be used and disclosed and how you can access medical information. This notice also describes your rights in accessing and amending your medical health information.

Protected Health Information (PHI) is the information, either verbal or recorded, that is created or received by the Barren River District Health Department and its eight county centers. This is information that is used to provide services to you or information that allows us to receive reimbursement for services provided to you or anyone you may represent, such as dependents.
We will use and disclose protected health information in the following ways:

WITHOUT your signed authorization:

- **Treatment/Services:** This includes the provision or management of healthcare and related services. ***We will not disclose psychotherapy notes, PHI for marketing purposes, and disclosures that constitute a sale of PHI without your authorization.***
- **Payment:** We will request payment from any payer source you list as a provider of reimbursement.
- **Healthcare Operations:** We may obtain services from other health care providers (business associates) to provide further evaluation, in order to meet state-mandated protocols or legal services. We will share your PHI with our business associates as necessary. All of our business associates have agreed to all required confidentiality agreements to protect your information.
- **Public Health Law:** We will, as required by law, disclose your PHI to state and federal public health agencies as mandated, including the reporting of disease, injury, abuse and neglect and public health surveillance. This information will be given ONLY to authorized staff at the state and federal level of government.
- **Other:** We will disclose your PHI in the following situations without your signature: Food & Drug Administration regulations, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity & national security and Workers' compensation.

Unless you object, we may disclose your PHI to notify a family member or other personal representative in an emergency situation.
We will contact you about *appointment reminders* and other health-related services that we may offer at the Barren River District Health Department and its local centers.
Other disclosures will be made only with your consent.

YOUR RIGHTS:

- You have the right to request restricted access to all or part of your PHI in writing to our district office or local county office in the format in which it is maintained.
- You must authorize the disclosure of psychotherapy notes, PHI or marketing purposes, and disclosures that constitute a sale of PHI.
- You have the right to restrict certain disclosures of PHI to a health plan where you have paid out of pocket in full for the health care item or service.
- You have the right to receive copies of your PHI. This request must be made in writing.
- You have the right to request that your medical record be amended to correct what you feel to be incorrect information. You may file a statement of disagreement with the contents of your medical record. Your statement will be reviewed by our Privacy Officer. If your amendment is denied, this denial will be attached to your medical record, along with your statement, and be disclosed with all further PHI releases.
- You have the right to complain if you believe we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. For further information on filing a complaint, contact the Privacy Officer at the Barren River District Health Department at the address or phone number listed below.
- You have the right to be notified following a breach of unsecured PHI.

Please contact the Barren River District Health Department's Privacy Officer if you have questions about this notice or if you believe your privacy rights have been violated.

Attn: Privacy Officer
Barren River District Health Department
P.O. Box 1157
Bowling Green, KY 42101
(270)781-8039

Barren River
DISTRICT HEALTH DEPARTMENT
Barren, Butler, Edmonson, Hart, Logan,
Metcalfe, Simpson, and Warren Counties

CONSENT FOR DENTAL TREATMENT

SCHOOL NAME_____ **HOMEROOM TEACHER**_____

CHILD'S NAME _____ BIRTHDATE:_____ RACE:_____ HISPANIC ☐Y ☐N

ADDRESS: _____ ☐MALE ☐FEMALE

SCHOOL THIS CHILD ATTENDED LAST YEAR_____

CHILD'S SOCIAL SECURITY #:_____ HOME PHONE #:_____ WORK/CELL#:_____

EMERGENCY CONTACT NAME: _____ PHONE#_____
Who does the child live with? _____

KY MEDICAID #(if applicable):_____
STUDENT'S DOCTOR: _____ DOCTOR'S PHONE #:_____
STUDENT'S DENTIST: _____

WHEN WAS HIS/HER LAST DENTAL CHECK-UP? _____ DOES YOUR CHILD REGULARLY SEE A DENTIST? _____

Has your child ever had any of the following:
Y / N – Any Operations
Y / N – Bleeding Problems
Y / N – Convulsions / Epilepsy
Y / N – Diabetes
Y / N – Hearing Impairment
Y / N – Heart Murmur
Y / N – Heart Problem of Any Kind
Y / N – Hemophilia
Y / N – HIV+ / AIDS
Y / N – Hyperactive
Y / N – Rheumatic Fever / Scarlet Fever
Other-

DOES YOUR CHILD REQUIRE PRE-MEDICATION(antibiotics)? ***Please circle YES NO***

Please circle one if applicable Pregnant Taking oral contraceptives

ALLERGIES/ASTHMA (food, insects, medication, other)_____

CURRENT MEDICATIONS: _____

CONSENT FOR HEALTH SERVICES AND ASSIGNMENT OF BENEFITS (Expires 1 year from date signed)

I certify that my answers are correct and complete to the best of my knowledge. Of my own free will, I consent to care which may include dental assessments/exams, dental cleanings, x-rays, fluoride treatments, amalgam(silver)and/or composite(white) fillings, minor extractions(tooth or teeth pulled) and dental sealants by a Dentist and/or a Public Health Registered Dental Hygienist affiliated with the Barren River District Health Department. The dentist will be present to perform the exam, fillings, and extractions but may or may not be present during the cleaning, fluoride, x-rays and sealant appointment. If your child has cavities or needs an extraction of a tooth, they may be referred out to a participating dentist with BRDHD. I understand that no guarantees are being made as to the effect of any exam or treatment on my child. I understand that my child may be tested for HIV infection, Hepatitis B, or other diseases carried by the blood or body fluids if such tests are needed only in the event that a healthcare worker is exposed to his/her blood, body fluids or tissue. I authorize the dental clinic to release dental information about my child, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to his/her primary care provider and to share relevant dental information (history of allergies or significant dental history) with school staff who may need to provide care to my child in an emergency. I understand that the sharing of this information is on a need to know basis only. I request that payment of authorized medical insurance benefits be made to Barren River District Health Department on my behalf, for services my child receives. I also authorize the local health department to release dental information about my child to Medicaid/KCHIP to determine payment for services. I also understand by signing this consent, I acknowledge that I have received a copy of the Barren River District Health Department's Privacy Notice. I have read the above and I understand the items above as they apply to me. Signature below indicates I do consent, authorize and declare as stated above. This permission can be revoked at any time.

_____ _____ _____
(Signature of Parent/Guardian) (Printed Name of Parent/Guardian) (Date Signed)