(Place patient label here if blank, or handwrite Name, DOB, & MRN)

Akron Children's

SCHOOL-BASED SUPPLEMENTAL HEALTH SERVICES MULTI-DISCIPLINARY CONSENT FORM

School Name:

PLEASE COMPLETE ALL OF THE INFORMATION BELOW- Please print using Ink (incomplete forms will not be accepted)

FIRST NAME (of student)		LAST NAME (of student)	
Gender: Male Female (assigned at birth)	Birthdate: (mo/day/yr)	Age	Grade
Preferred Pronouns: (he/she/they)	Preferred Language:	Address	
Home Phone #	Cell Phone #	City / State / Zip Code	
Do you have a primary doctor? ☐ YES (list below) ☐ NO Doctor's Name: Phone #:		Pharmacy Name: Address:	

PARENT/GUARDIAN INFORMATION

First Name:	Last Name:	Phone #:	Relationship to Student:

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPRIATE BOX)

Insurance Name:	
Insurance Address:	
Subscriber Name/ID #	Subscriber DOB:
MMIS:	Group #:

☐ NONE, please connect me to Children's Financial Counselor

All services provided are billed to insurance. If you do not have insurance, Children's will connect you to financial assistance. No child is denied services for inability to pay.

STUDENT HEALTH HISTORY

Allergies: ☐ YES (list below) ☐ NO

Medications: ☐ YES (list below) ☐ NO

Other medical problems/health concerns: ☐ YES (list below) ☐ NO

CONSENT FOR SCHOOL BASED HEALTH CENTER SERVICES

I have read this consent form or have had it read to me, and it has been explained to my satisfaction. This consent is valid until the student is no longer enrolled in the School or until revoked by me in writing to Children's. To revoke your consent, submit your revocation in writing to the Privacy Officer at Akron Children's Hospital, One Perkins Square, Akron, Ohio 44308.

By signing below, I acknowledge that I understand and accept the terms of this consent and confirm that I have legal ability to consent for the treatment. I agree that I will promptly inform the School-Based Health Center in writing of any changes in my child's physical health and any change in the custody of my child which affects my ability to provide this consent on behalf of my child.

NOTE: In some situations Ohio law permits a minor to consent to medical care without parental consent. For example, parental consent is not required for contraception, pregnancy testing, and prenatal care; sexually transmitted disease testing and diagnosis; HIV testing; treatment of drug and alcohol related conditions; and certain outpatient mental health services. Further, parental consent is not required for the application of first aid treatment or in an emergency.

PLEASE CHECK THE BOX(ES) FOR THE SERVICES BEING REQUESTED:

☐ School Based Health Medical Services ☐ School Based Asthma Therapy Program ☐ School Based Behavioral Health

Time Period During Which Consent is Authorized:
From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School

Printed Name of Parent/Legal Guardian	Date of Birth	Signature of Parent/Legal Guardian	Date Time
Printed Name of Witness #1 to Signature if Verbal Consent *(health care personnel only)*		Signature of Witness #1	Date Time
Printed Name of Witness #2 to Signature if Verbal Consent *(health care personnel only)*		Signature of Witness #2	Date Time

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Akron Children's Hospital

HIPAA AUTHORIZATION to RELEASE MEDICAL RECORDS (FROM Children's)

Please fill out completely.

FREE DOWNLOAD to Sign with Adobe Reader — Get Adobe Reader

MRN _____ *Facility Use Only*

Patient Information

Patient Name: _____ _____
Last First Middle (any previous name) Date of Birth

_____ _____
Patient Street Address City State Zip Phone

Release To

Release Information TO the following Person(s) or Organizations:

Name/Organization: _____ Attention: _____

_____
Address City State Zip

_____ _____ _____
Phone Fax Email Address

Purpose

Person/Place requesting records (check all that apply):
☐ Patient/Parent/Legal Guardian ☐ Doctor/Hospital ☐Lawyer ☐ Insurance Company ☐ Other _____

Purpose of Release (check all that apply):
☐ Patient Care ☐ Disability ☐ Insurance ☐ School ☐ Legal ☐ Personal Use ☐ Other_____

Method of Release

Format of records to be released:
☐on paper ☐ PDF [on CD or Jump Drive (if available)] ☐ Verbal communication only with person or agency listed above
Information May Be Sent Via: *(Note: Radiology images can only be placed on CD and mailed)*
☐ Mail Delivery ☐ Fax ☐ Encrypted Email* ☐ to MyChart* (*electronic records only, size restrictions apply)

Information to Release

Dates of Treatment Requested: _____ (If not specified, the **LAST 6 MONTHS** will be released)

☐ **Medical Record Abstract** – pertinent information generally used for continued care/personal use/disability.
The following items are included in a Medical Record Abstract:
After Visit/Discharge Summary, Emergency Record, History & Physical, Inpatient Consult Report(s), Operative Report(s), Radiology Report(s), Lab or other Test(s)

Other Information Requested (choose any to release):
☐ Lab/Pathology Reports
☐ Radiology Reports
☐ Radiology imaging on CD
☐ Vaccination (shot) records
☐ Other imaging (specify): _____
☐ Billing Records
☐ Appointment list
☐ Demographic page

☐**Doctor's Office Reports** (Doctor or Department Name): _____

☐**Other** (please list exact documents): _____

Patient/Parent/Legal Guardian

This authorization expires one year from the date of signature, OR on this date / event: _____

I understand that treatment does not depend on me signing this Authorization. I understand that my/my child's/my ward's medical record might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse. I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer be protected by the Federal privacy regulations, and this person or organization might release the records to someone else, except as prohibited by 42 CFR Part 2 or other applicable law. I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already released. If I want to revoke it, I must notify the Privacy Officer, in writing, at Akron Children's Hospital, One Perkins Square, Akron, OH 44308.

By signing below, I affirm that I am the patient and/or the patient's personal representative, and have the authority to authorize who may access or receive the patient's health information.

Mandatory My relationship to the patient is: ☐ Self ☐ Parent ☐ **Legal Guardian-if this box is checked, you must attach Court Order to show your authority to sign***

_____ _____ _____
Signature of Patient or Parent/Legal Guardian Printed Name Date

_____ _____ _____
Signature of Witness Printed Name Date

Submit

Submit **completed form** AND a **copy of a valid Photo ID** (if a current one is not on file with us) to:

Mail form to:	**Fax** form to:	**Email** form to:	**Questions? Call**:
Akron Children's Hospital- Attn: HIM One Perkins Sq., Akron, OH 44308	330-543-5360	records@akronchildrens.org	330-543-8552