



School Based Health Center Enrollment Form ☐ New ☐ Renewal

(Please print the name of school)

Student Information

Student Name: _____

Street Address: _____ City: _____ ZIP: _____

Date of Birth: _____ Student SSN: _____

Sex: ☐ Female ☐ Male Race/Ethnicity: _____

School Grade (circle one): 6 7 8 9 10 11 12

Parent/Guardian: _____ Relationship to Student: _____

Preferred Phone: (W) _____ (H) _____ (C) _____

Email Address: _____

Emergency Contact

Would you like to use the provided emergency contacts on file with the school to receive information about your student in the event that we are unable to reach you? ☐ Yes ☐ No **IF NO, please list emergency contacts:**

Emergency Contact or person who can receive info about your child in the event that we are unable to reach you.

Name	Phone Number	Relationship to Student
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Student Health Info.

Allergies to medicines: ☐ Yes ☐ No If Yes, _____

Allergies to food: ☐ Yes ☐ No If Yes, _____

Currently has or has had in the last 2 years:

☐ Allergies/Hay fever	☐ Anxiety	☐ Asthma	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Reflux	☐ Sickle Cell Anemia
☐ NONE	☐ Other: _____		

Current Medications:

Surgeries (type\year)

1. _____
2. _____
3. _____

1. _____
2. _____
3. _____

Other _____

Doctor's name: _____ Phone: _____

Pharmacy name: _____ Phone: _____

Type of ☐ Private (name) _____ Is Student active in School Sport or Club?

Insurance: ☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Yes ☐ No

Consent for Services and HIPPA Information

Statement of Consent: I, the parent/guardian of said student, give consent for my child to receive services at the SBHC. I understand that this consent form will be good until my child leaves/ graduates school or until I provide the Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes. **If your child attends North Central Middle School, You are also giving SBHC staff permission to transport your child from North Central Middle School to the SBHC at NCHS.**

Confidentiality between the student, parents and the health center is assured. In accordance to state and federal law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact. Any health information and emergency contacts can be obtained from school district for the purpose of medical treatment or pharmacy.

Release of Information: In order to provide for the medical and/or mental health care of my child as may be provided by SBHC, the USC School of Psychology and Kershaw County School District counselors (RBHS), I authorize my child's school and/or healthcare providers and pharmacy to discuss, disclose, and/or release the contents of my child's complete health record to SBHC, the USC School of Psychology and Kershaw County School District counselors (RBHS) including records relating to mental healthcare and communicable diseases for the purpose of providing continuity of care. This medical information may be used by SBHC, the USC School of Psychology and Kershaw County School District Counselors (RBHS) for medical treatment or consultation, billing or claims payment, or other purposes as needed to appropriately attend to my child's healthcare needs. I understand that these different entities are collaborating with each other to provide the best possible care for my child at the SBHC and it is important that these entities share my child's private medical information amongst themselves in order to provide this care. Information may also be used to report outcomes for evaluations for funding entities .

I understand that I have the right to revoke this authorization, in writing, at any time. This Release of Information will remain in effect until terminated by me in writing.

HIPAA Release: The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing or discussing any aspect of your health and medical information with anyone who is not directly involved in your care. The CHS-SBHC staff is committed to ensuring that your child receives appropriate care and his/her information is protected.

Signature of Parent / Legal Guardian

Date

_____ These initials signify I have received a copy of the CMC Privacy Statement

**Community Medical Clinic of Kershaw County
Post Office Box 217
Camden, SC 29021**

Updated 09/10/2018
Revised 05/31/2019



Privacy Statement

Revised 5/30/2019

This information describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PLEDGE REGARDING HEALTH INFORMATION We understand that information about you and your health is personal. We are committed to protecting your health information. We will create a record of the care and services you receive at Community Medical Clinic of Kershaw County (CMC). We need this record to provide you with quality care and to comply with certain legal requirements. This notice will apply to all of the records of your care generated by CMC. This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

1. Make sure that health information that identifies you is kept private.
2. Give you this notice of our legal duties and privacy practices with respect to your health information.
3. Follow the terms of the notice that is currently in effect.

HOW WE MAY DISCLOSE YOUR HEALTH INFORMATION The following categories described different ways that we may use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within at least one of the categories.

For Treatment. We may use your health information to provide you with medical treatment or services. We may disclose your health information to doctors, nurses, technicians, medical students or other CMC personnel who are involved in taking care of you. We may also disclose your health information to people outside of CMC to provide services that are a part of your medical care.

HIV & AIDS Testing. If you are tested for HIV or AIDS, we will not release any information about your test results or treatment, except in the following circumstances:

1. You give us permission to release the information.
2. We are required or permitted by law to disclose the information.
3. A court order or subpoena requires us to release this information.

For Healthcare Operations. We may use and disclose your health information for healthcare operations. This is necessary to run CMC and give quality care to our patients. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many CMC patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

We may disclose information to doctors, nurses, technicians, medical students and other personnel for review and learning purposes.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care at CMC.

Individuals Involved in Your Care. We may release your health information to a family member, other relative, close personal friend, or any other person who is involved in your care.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or reduce the threat.

SPECIAL SITUATIONS

Public Health Risks. We may disclose your health information for public health activities. These activities generally include the following:

1. To prevent or control disease, injury or disability.
2. To report births and deaths.
3. To report child abuse or neglect
4. To report reactions to medications or problems with products.
5. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
6. To notify the appropriate government authority if we believe an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

1. In response to a court order, subpoena, warrant, summons or similar process.
2. To identify or locate a suspect, fugitive, material witness, or missing person.
3. About the victim of a crime if under certain limited circumstances, we are unable to obtain the person's agreement.
4. About a death we believe may be the result of criminal conduct.
5. About criminal conduct at CMC.
6. In emergency circumstances to report a crime; the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as necessary for them to carry out their duties.

National Security and Intelligence Activities. We may release your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may also disclose your health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or others conducting special investigations.

Blood Testing. While you are receiving care, a healthcare worker may accidentally be exposed to blood or other body fluids. If this occurs, your blood will be tested for the presence of certain diseases (for example, HIV, Hepatitis B and C). These tests are necessary to help protect the healthcare worker. The results of these tests will be a part of your medical record and will not be released except with your prior consent or as required or permitted by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission.

If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made with your permission. We are required to retain records of the care that we provide to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION You have the following rights regarding the health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually this includes medical records but may not include psychotherapy notes or psychiatric/substance abuse notes. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department. We will respond to you within 30 days of receiving your written request.

We may deny your request to inspect and/or obtain a copy of your health information in limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Clinic will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for CMC. To request an amendment, your request must be made in writing to the Medical Director, Community Medical Clinic of Kershaw County, PO Box 217 Camden, SC 29021. We will respond within 60 days of receiving your written request.

Right to Request an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made concerning your health information, but, does not include disclosures made for treatment or for healthcare operations, or for purposes or disclosures specifically authorized by you.

To request this list or account of disclosures, you must submit your request in writing to the Medical Director, Community Medical Clinic of Kershaw County, PO Box 217, Camden, SC 29020. Your request must state a time period which may not be longer than six years. The first list you request with a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost is incurred. We will respond within 60 days of receiving your request. The list will include the date of the disclosure, to whom health information was disclosed (including

address, if known, a description of the information disclosed, and the reason for the disclosure.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about your treatment, payment, or healthcare options. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care, like a family member or a friend. For example, you could ask that we not use or disclose information about a surgery you had. To request restrictions, you must make your request in writing. In your request, you must tell us (1) **What** information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You may not limit uses and disclosures that we are legally required or allowed to make.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or at home. To request confidential communications, you must make your request in writing to the Medical Director, Community Medical Clinic of Kershaw County PO Box 217, Camden, SC 29021. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may obtain a copy of this notice at any time from the Clinic.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. The notice will contain the effective date on the first page. You can view the current notice at the Clinic. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
2. Is not part of the health information kept by or for CMC.
3. Is not part of the information which you would be permitted to inspect and copy.
4. Is accurate and complete.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Clinic. If you have any questions about this notice or any complaints about our privacy practices, please contact the Medical Director at Community Medical Clinic of Kershaw County, PO Box 217, Camden, SC 29021. You will not be penalized for filing a complaint.

For more information: www.hhs.gov/ocr/privacy