Example of an informed consent form that can be used to assist in enrolling children into a SBTH program:

School Based Health Center Procedure Manual Onsite and Telemedicine Services

PRIVACY PRACTICE CONSENT FORM

(Consent to treatment, transportation, and authorization to release information and assignment of benefits)

The Lamar County Board of Education has joined in partnership with McIntosh Trail Community Service Board to develop this school-based collaborative healthcare center.

The primary focus of the center is to provide quality, accessible health care to the children of Lamar County Schools, in order to have a positive impact on the children’s health, school attendance, and academic performance.

In order for your child to receive services at the health center, this consent form must be completed and proper documentation of insurance obtained.

I hereby voluntarily give my consent for ___________________________ to receive health services, including telemedicine services, at the Lamar County School Based Health Clinic. I further authorize any physician or physician-designated health professional working for the clinic to provide such medical tests, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of their health care.

I authorize release of information from medical records of the family doctor or primary care provider designated by me whenever necessary for my child’s care including referrals and/or emergency services.

I authorize release of written and verbal information pertinent to my child’s health care from the Lamar County School staff to the Lamar County School Based Health Clinic whenever necessary for my care.

I authorize Lamar County Public Health to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law.

Medicaid and other insurers will be billed for services rendered.

If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness, I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I understand that my signing this consent allows the physicians and professionals at Lamar County School Based Health Clinic to provide health, and telemedicine, services, I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

I have read and understand the above information and give permission for treatment at The Lamar County School Based Health Clinic. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at (770) 358-1483.

______________________________
NAME OF PARENT OR LEGAL GUARDIAN

______________________________
SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE