HOWARD COUNTY HEALTH DEPARTMENT

Bureau of Family Health Services
8930 Stanford Blvd | Columbia, MD 21045
410.313.7500 - Voice/Relay
410.313.7502 - Fax
1.866.313.6300 - Toll Free

Maura J. Rossman, M.D., Health Officer

Dear Parent/Guardian,

The Howard County Health Department and Howard County Public Schools have partnered to provide comprehensive health care services in the School-Based Wellness Centers operating in select schools. The School-Based Wellness Centers offer the following health care services by appointment to **all students regardless of health insurance or family income:**

- Physical exams - annual, sport, camp, and college entry
- Diagnosis and treatment of acute illness and injuries – **Walk-in appointments may be available**
- Management of chronic health problems such as asthma, obesity and acne
- Prescription medication and routine laboratory tests such as strep throat, urine infections and sexually-transmitted infections
- Health screenings - behavioral/mental and reproductive health
- Referrals for services not provided in the school-based wellness center
- Health education

The Center's physicians and nurse practitioners provide health services only during the school day and do not replace your child's regular health provider. The Center staff works with your child's provider to coordinate his or her care. A copy of your child's visit will be sent to your child's regular provider to coordinate treatment and care management.

The School-Based Wellness Center will bill Medical Assistance only. **Families will not be responsible for any co–pays or for charges not covered by health insurance.**

Your signed consent and completion of the attached packet is required for your student to be enrolled and receive services in the School-Based Wellness Center except for services covered under the Maryland Minor Consent Laws.

Additional information can be provided and appointments made by emailing Howardsbwc@howardcountymd.gov , visit the Howard County Health Department website at www.howardcountymd.gov/health/school-based-wellness-centers , or call 410-313-6362.

HOWARD COUNTY HEALTH DEPARTMENT

Howard County Health Department
School-Based Wellness Centers Program
Parent/Guardian Consent Form

STUDENT INFORMATION

Last Name: _____

First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Email: _____

Date of Birth: _____ _____ _____
Month Day Year

Social Security Number (optional) _____

Sex/Gender Male ☐ Female ☐

Transgender Male ☐ Transgender Female ☐ Non-Binary ☐

Ethnicity (please check one)
☐ Hispanic ☐ Not Hispanic

Race (please check all that apply)

☐ American Indian/Alaska Native ☐ African American/Black ☐ Asian

☐ Native Hawaiian/Other PI ☐ White ☐ Other

Preferred Language: _____

Name of School: _____

Grade: _____

PARENT/GUARDIAN INFORMATION

Mother:

Last Name: _____

First Name: _____

Contact Number(s): _____

_____

Email Address: _____

Father:

Last Name: _____

First Name: _____

Contact Number(s): _____

_____

Email Address: _____

Legal Guardian (if nonparent):

Last Name: _____

First Name: _____

Contact Number(s): _____

_____

Email Address: _____

HEALTH INSURANCE INFORMATION

Type of Insurance: ☐ Private (Employer) ☐ Medical Assistance ☐ No Insurance

If your child does not have insurance, would you like staff from the Howard County Health Department contact and assist you with applying for insurance? Yes ☐ No ☐

We only bill Medical Assistance and families are never responsible for any portion of an unpaid bill.

Name of Managed Care Organization: _____

Maryland Medicaid Number: _____ Member ID: _____

HOWARD COUNTY HEALTH DEPARTMENT

Howard County Health Department
School-Based Wellness Centers Program
Parent/Guardian Consent Form

Student Name: **School:**

SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services in the School-Based wellness Center by the State-licensed medical providers employed by or contracted with the Howard County Health Department. I further understand that under Maryland Minor Consent Laws, a minor (a person under the age of 18) has the same capacity as an adult to consent to receiving education and referral for: substance abuse, reproductive health, mental health issues (16 years or older), and the diagnosis and/or treatment of sexually transmitted diseases without parent/guardian notification or consent. Pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Wellness Center services may include, but are not limited to:

- Health screening and comprehensive physical examinations (complete medical examination) including those for school entry exams, annual well-child checks, sports physicals, camp, and college entry physicals.
- Medically prescribed, basic laboratory tests which may include venipuncture and testing of other body fluids, such as urine or throat and wound secretions, for conditions including anemia, sexually transmitted diseases, strep throat, and diabetes
- Medical care and treatment, including diagnosis of acute and chronic illnesses and diseases and injuries and other health conditions, and dispensing and prescribing of medications
- Immunizations
- Referrals for services not provided at the school-based wellness center
- Annual health questionnaire/survey and health education and risk preventions counseling
- Appointments via telemedicine when in-person visits are not possible.

Signature of Parent/Guardian (required) **Date:**

By signing here, I give permission for my student to have a visit even if the school nurse is unable to contact me at the time of the visit. I understand this is only for students in second grade or older.

Signature of Parent/Guardian (optional) **Date:**

HOWARD COUNTY HEALTH DEPARTMENT
FACT SHEET FOR PARENTAL CONSENT FOR REALEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my student to release any medical or other information, directly or through the Chesapeake Reginal Information System for Patients, to assist in the management and care coordination of my student's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of the information shared. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my student's medical information and that I can change my mind at any time and revoke my authorization by writing to the School-Based Wellness Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my student's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:

Information Required by Law or School System:

- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

Information to protect Health and Safety:

- Conditions which may require emergency medical treatment
- Mental health conditions including evaluations, diagnosis, treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity

PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
I, the undersigned, voluntarily consent to treatment of my child by the provider and staff of the Howard County Health Department School Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my student's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I authorize payment directly to the HCHD for services for which HCHD accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

Signature of Parent/Guardian (required) **Date:**

Time Period During Which Release of Information is Authorized:
From: Date form is signed To: Date student is no longer enrolled in School-Based Wellness Center

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
Medical and Family History Questionnaire

Student's Name:	Today's Date:

FAMILY HEALTH INFORMATION

Do any of the student's family members (parents, sisters, brothers, grandparents) have or had the following:

Health Problem	Yes	No	Which Family Member?
Asthma			
Diabetes			
Mental Health/ Psychiatric Problem			
Sickle Cell			
Tuberculosis			
Heart Problems			
Other:			

Who is the student's regular health care provider?

Name: _____ **Office Telephone:** _____

Address: _____

When was your student's last physical or well child exam? _____
Month/Year

Please provide the name and phone number of your pharmacy.

Name: _____ **Phone Number:** _____

STUDENT'S HEALTH INFORMATION

Please place a check in the box for any health problems your student has had.

☐ Asthma	☐ Attention Deficit Disorder	☐ Bleeding Problems	☐ Mental Health Issues
☐ Diabetes/Endocrine Disorders	☐ Ear infection (frequent)	☐ Epilepsy/Seizures	☐ Headache (frequent)
☐ Hearing	☐ Heart Problems/Murmur	☐ Developmental Problems	☐ Sickle Cell Anemia
☐ Tuberculosis	☐ Vision	☐ Other	

☐ **Allergies (list all including insects, food, and medications):**

If your student has been hospitalized, please provide the date(s) and reason(s):

Please list all prescribed and over the counter medications your student takes:

Name of Medication	Dose/Amount Taken	Times per Day

Maryland
DEPARTMENT OF HEALTH

MDH Privacy Office
Internal Controls, Audit Compliance
& Information Security (IAC/S)
Office: 410-767-5411
mdh.privacyofficer@maryland.gov

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical records
- Correct your paper or electronic medical records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you or help manage the health care treatment you receive
- Run our organization
- Bill or pay for your services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical records	• You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 21 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical records	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share information about that service or item for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we have shared information	• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost- based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have previously agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 5. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
  (MDH entities generally do not maintain directories for disclosures to callers or visitors. However, if a MDH entity does maintain a directory, the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.)

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you and help manage the health care treatment you receive	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. • **Any of our health care components considered health plans are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill and Pay for your services	• We can use and share your health information to bill and get payment from health plans or other entities or if applicable, to pay for your services.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Information Purposes	• Unless you provide us with alternative instructions, we may send appointment reminders and other materials about the program to your home.
Particularly Sensitive Conditions	• Certain MDH facilities, units, and staff specialize in providing substance use disorder treatment (Programs). The confidentiality of substance use disorder patient records maintained by these Programs is protected by special Federal law and regulations, in addition to HIPAA. • Certain other types of health information may have additional protection under Maryland law. For example, health information about HIV/AIDS and mental health information is treated differently than other types of health information under Maryland law. These categories of information generally will not be disclosed without your consent.
Health Information Exchange	• MDH has chosen to participate in Chesapeake Regional Information System for our Patients, Inc. (CRISP), the designated health information exchange (HIE) in Maryland. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. If you do NOT want CRISP to share your health information, you can opt-out of CRISP at any time by calling 1-877-952-7477 or submitting a completed Opt-Out form to CRISP by mail, fax or through their website at **www.crisphealth.org.** Your health care providers will still have the option to use CRISP to get your data sent directly to them from labs. Also, Maryland law does not allow you to opt-out of public health reporting, such as reporting specific diseases to public health officials or having information about your prescriptions shared with the Maryland Prescription Drug Monitoring Program (PDMP). CRISP is required to make these reports even if you have opted out.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- If federal privacy law and Maryland law conflict and the Maryland law is more protective of your information or provides you with greater access to your information, then we will follow the Maryland law.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind about any of the rights or choices described in this notice.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site at **https://health.maryland.gov/pages/privacy.aspx.**

This notice is effective on July 1, 2023

This Notice of Privacy Practices applies to the following organizations.

This notice applies to Maryland Department of Health (MDH) Covered Components. MDH has been designated as a "hybrid entity" under the HIPAA regulations, because it performs a variety of health care and public health activities. The MDH covered components are the components that perform health care activities. For a list of covered components, please visit https://health.maryland.gov/docs/p010306.pdf and consult the appendix. MDH may use non-MDH entities (known as Business Associates) to perform the permitted activities. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.

Insert agency privacy official contact information in box below.

Antigone Vickery
Deputy Health Officer
Howard County Health Department

Office: 410-313-5839

acickery@howardcountymd.gov

MDH Privacy Office

Internal Controls, Audit Compliance
& Information Security (IAC/S)

Office: 410-767-5411

mdh.privacyofficer@maryland.gov

Maryland
DEPARTMENT OF HEALTH

ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. The Maryland Department of Health (MDH) wants to assure you that your medical/protected health information is secure with us. Our Notice of Privacy Practices contains information about how we will ensure that your information remains private. We encourage you to read our Notice of Privacy Practices for a more complete description of the uses and disclosures of your health information.

MDH participates in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. Find more information about CRISP medical record sharing policies at www.crisphealth.org.

MDH can and will use your information to conduct, plan and direct your treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers and conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received the Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may use the contact information listed on the last page of the Notice of Privacy Practices. I further understand that MDH has the right to change its Notice of Privacy Practices from time to time and that I may contact MDH at any time to obtain a current copy of the Notice of Privacy Practices.

_____	_____	_____
Patient Signature	Print Patient Name	Date
_____	_____	_____
Parent\Personal Representative Signature	Print Parent\Personal Representative	Date

If signed by Parent or Personal Representative, please indicate Relationship to Patient

☐ Parent of Minor Child ☐ Guardian ☐ Authorized Representative

☐ Other_____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

For STAFF USE: Complete only if signature is not obtained. Please check the box that best applies.

☐ Refused to sign

☐ Patient to receive anonymous testing, wishes to remain anonymous

☐ Emergency situation, unable to secure signature

☐ Other (please describe): _____

_____	_____	_____
Staff Member Signature	Print Staff Member Name	Date