



COMPREHENSIVE ON-SITE HEALTH CARE FOR ALL DPS CHILDREN

Who can use a SBHC?

Any DPS student is eligible to use a SBHC. Students are eligible regardless of insurance status or ability to pay. SBHC can serve as the primary point of care for a student or can work in conjunction with a student's primary care doctor.

Why choose a SBHC?

SBHCs offer convenient care that limits the amount of time students are out of class and parents/guardians have to be off work. In many cases, students are able to get same or next day appointments.

What services may be offered?

- Well Child Checks which meet the requirements of school, sports, camp, and employment physical exams. This may include routine lab tests, and immunizations
- Prescriptions and medications
- Care for chronic conditions such as asthma and depression
- Care for acute injury and illness
- Reproductive health services including pregnancy testing and birth control evaluation, dispensing and management
- Testing and treatment for sexually transmitted infections
- Individual, group and family mental health counseling
- Dental screenings, routine cleanings, fluoride varnish application, sealants and dental x-rays
- Parent and child health education

Who provides services?

- Nurse Practitioner, Physician Assistant or Physician
- Mental Health Therapist or Psychiatrist
- Substance Abuse Counselor
- Health Care Partner/Medical Assistant
- Health Educator
- Community Health Advisor/Outreach Worker
- Dental Hygienist

Parent involvement?

A parent or guardian must sign a consent form before their child may use any health center service. Once this is done, the child may use the health center at any time during the 18 month consented period.

Supporting family communication is a principle goal of the health center. Clinic staff encourages patients to discuss their health care with their parents. However, parents are not routinely notified when a patient uses the health center, except by patient request or when the staff becomes aware of serious health concerns.

Confidentiality?

Colorado state law allows some visits to the health center to be confidential as appropriate. Information is not shared without patient and/or parental permission. The only exception is a life-threatening situation.

What does it cost?

There is no charge to the patient or their family for services offered in the health center. Patients will not have to pay co-pays, deductibles or fees to be seen. Insurance may be billed but without cost to families.

Insurance enrollment help?

When registering for use of the clinic, families are asked to provide health insurance information or to apply for low-cost child health insurance options and discount programs. Insurance outreach and enrollment staff are available through the School-Based Health Center to assist families with the insurance application process.

Consent Signature Checklist:

- Denver School-Based Health Center Services (DSBHC) General Parent/Guardian Consent for Treatment
- Denver School-Based Health Center Immunization Consent Form
- Parent/Guardian Questionnaire Child/Teen/Family History
- Notice of Privacy Practices
- Outpatient General Consent for Treatment and Terms Relating to Payment ("Consent")

DENVER HEALTH
DENVER SCHOOL-BASED HEALTH CENTER SERVICES (DSBHC)
GENERAL PARENTAL/GUARDIAN
CONSENT FOR TREATMENT

NAME: _____

DOB: _____

MRN: _____

I give consent for my student _____ Sex: M F DOB: _____
First Name Middle Last Name

to receive necessary and/or advisable care provided by the DSBHC. I understand the following services may include:

physical exams • immunizations • routine lab tests • care for acute illness and injury • prescription medications • care for common adolescent physical concerns (weight, acne, menstrual problems) • care of certain chronic conditions such as asthma and seizure disorder • pregnancy testing • diagnosis and treatment of sexually transmitted infections • family planning, abstinence counseling, the administration and management of birth control • prenatal/postpartum care services • drug and alcohol prevention counseling and education • mental health services including individual, family and group therapy • follow-up care as needed

Dental services available in the DSBHC include screenings, routine cleanings, x-rays, fluoride varnish application, and sealants. Any diagnosis or assessment completed solely by the registered dental hygienist is for determining necessary dental hygiene services only. It is recommended by the American Dental Association that a dentist perform a comprehensive dental examination twice each year.

Release of Information: I understand my student's medical record is protected health information and all requests for my student's medical records require a signed consent by student's parent/guardian. DSBHC may disclose health information for payment, treatment, and health care operations as described in Denver Health's Notice of Privacy Practices. As allowed by Colorado law, my student may request confidential visits meaning all health information from the visit will remain confidential. Access to my student's medical records from a confidential visit will remain confidential and release of medical records to parent/guardian or any interested party requires a signed release of information from the student. I give my permission to DSBHC staff to examine and/or copy my student's school records including immunization records, attendance, and any records that are necessary for DSBHC staff to provide the care and/or treatment for my student.

I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services my student receives at a school-based health center, and is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and this data does not specifically identify any individual patient.

DSBHC Fees, billing, authorization, and consent: On behalf of my student, I assign to Denver Health and Hospital Authority ("DHHA") any and all benefits that either my student or I may be entitled to receive for healthcare services provided by DSBHC from any payer of benefits including any person, entity, insurance company, health benefit plan, or governmental healthcare program. DHHA has authorization to file claims with, and collect payments from, the payer of benefits, and the payer of benefits to make payment directly to, and solely to the order of, DHHA. I agree to assist DHHA in submitting and collecting claims from the payer of benefits in any reasonable manner requested. I authorized DHHA and its care providers to disclose to the payer of benefits any information from my student's medical and billing records necessary to obtain payment. I understand that once information is released DHHA will be unable to control its confidentiality.

Student's School: _____ Grade: _____ DPS Lunch ID #: _____

Student's Home Address: _____

Student's Race/Ethnicity circle all that apply (optional):

Hispanic/Latino American Indian White Black/African American Asian Other: _____

Mother/Guardian (Name): _____ Contact Phone Number: _____

Father/Guardian (Name): _____ Contact Phone Number: _____

Emergency Contact (Different than above): _____ Contact Phone Number: _____

Name of Student's Medical Clinic/Primary Care Provider: _____ Provider Phone Number: _____

Insurance Information - my student has health insurance coverage: YES NO

Health First CO (Medicaid) ID #: _____ CHP+ ID #: _____ CICP/DFAP

Name of Private Insurance: _____ Policy/Member #: _____

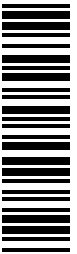
Group #: _____ Policy Holder's Name: _____ Relationship to Student: _____

Employer of Policy Holder: _____ Policy Holder Date of Birth: _____

CONSENT: I have received the DSBHC packet that explains the services provided by DSBHC. I understand this consent will remain valid for 18 months from the date of my signature. I understand that I am responsible to notify DSBHC with any changes in guardianship and/or insurance. I have the right to revoke this consent for my student at any time with written documentation to DSBHC stating this.

Signature Parent/Guardian: _____ **Date:** _____

Print Name of Parent/Guardian: _____



**DENVER HEALTH
DENVER SCHOOL-BASED HEALTH CENTER
IMMUNIZATION CONSENT FORM**

Student's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle MM DD YY

Student's School: _____ **Grade:** _____ **Sex:** Male Female

Parent or Legal Guardian name: _____

Vaccinations are offered at Denver Health School Based Health Centers to protect your student against many serious diseases. Prior to vaccinating, Denver Health checks multiple databases and records to confirm that students are only given vaccines they have not received.

Vaccines are designed to prevent life threatening, debilitating illnesses, and cancer. These include:

Disease	Vaccine	Disease	Vaccine	Disease	Vaccine
Tetanus	Tdap/Td/Dtap*	Polio	IPV*	Chicken Pox	Varicella*
Diphtheria		Hepatitis A	Hep A		
Pertussis		Hepatitis B	Hep B*	For children under 5 years old	
Measles	MMR*	Meningococcal Meningitis	MCV4	Severe diarrhea	Rotavirus
Mumps		Human Papillomavirus	HPV9	Bacterial Disease	HIB
Rubella		Influenza/Flu	IIV	Pneumonia	PCV13

NOTE: Each of these Vaccines is recommended by the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP). Vaccines marked with an () are required for school.*

- List the name(s) of the vaccine(s) you do **NOT** want your student to receive here: _____
- Has your student ever had a serious reaction to a vaccine?
 Yes If so, what was the reaction and to what vaccine? _____
 No

I give my permission for my student to receive vaccines at the School-Based Health Center, except for the specific vaccine(s) listed above. I request that those vaccines be given to the student named above, for whom I am authorized to make this request. I further agree to have information shared with my student's primary care provider. I also agree to have my student's immunization record stored in my student's school health record, the Denver Health electronic record (eHR), and the Colorado Immunization Information System (CIIS). Vaccine Information Statements (VIS) about the disease prevented and the risks and benefits of the vaccines given have been offered and my questions answered.

The Center for Disease Control (CDC) maintains a current list of Vaccine Information Statements (VIS) for each vaccine. For the most current VIS, please visit: <https://www.cdc.gov/vaccines/hcp/vis/current-vis.html>.

Please place an (X) next to one of the following options:

_____ **YES, I DO authorize Denver Health School-Based Health Centers to vaccinate my student.**

_____ **NO, I DO NOT authorize Denver Health School-Based Health Centers to vaccinate my student.**

Parent or Guardian Signature

Relationship to Student

_____/_____/_____
Date (MM/DD/YY)

DENVER HEALTH MEDICAL CENTER PARENT/GUARDIAN QUESTIONNAIRE CHILD/TEEN/FAMILY HISTORY

Child/Teen Health History

1. Does your child take **medication**? No Yes If yes, what? _____
2. Has your child had **serious medical** or **mental health problems**? No Yes
If yes, what? _____
3. Has your child been **hospitalized overnight** or had **surgery** or any **serious injuries**? No Yes
If yes, what? _____
4. Does or did your child have any of these problems **now** or in the **past**?
- | | |
|--|---|
| <input type="checkbox"/> Allergies to food, medicine, or other? If yes, to what and what was the reaction? _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Birth Problems | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Clots/Stroke | <input type="checkbox"/> Mental Illness/ Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Development/Learning Delays | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis / TB / Positive TB Test |
| <input type="checkbox"/> Drug / Alcohol Abuse | <input type="checkbox"/> Other _____ |

Family History

Does anyone in your family (parents, siblings, grandparents, aunts/uncles) have any of these problems, **now** or in the **past**?

	If so, who?	Maternal or Paternal side?
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Blood Clots/Stroke		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Drug/Alcohol Abuse		
<input type="checkbox"/> Heart Disease		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> High Cholesterol		
<input type="checkbox"/> Mental Illness/Depression		
<input type="checkbox"/> Sickle Cell Anemia		
<input type="checkbox"/> Tuberculosis / TB / Positive TB Test		

Parent/Guardian Signature

Date (mm/dd/yy)

Staff Signature/Title

Date (mm/dd/yy)

Time (00:00)

(Pager & Provider #)



Name, MR#, Pat#, DOB

DENVER HEALTH AND HOSPITAL AUTHORITY
NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

If you have any questions, contact a Patient Representative at 303.602.2915 or the Privacy Officer by phone at 303.436.8886; by fax at 303.602.7024; or by mail at 777 Bannock Street, MC 7776, Denver, CO 80204. To learn more about Denver Health, please see www.DenverHealth.org.

Medical information about you and your health is private. We strive to protect your health records when you are in the hospital and when you are being seen in the clinics. We will use your records to care for you, to bill for care, to run the hospital, and to comply with the law. This Privacy Notice applies at all Denver Health and Hospital Authority (Denver Health) inpatient, outpatient, community clinic, and emergency services sites except for parts of the Rocky Mountain Poison and Drug Center and Denver Public Health, which do not have to follow this Notice.

This Notice tells you about the ways Denver Health may use or give out information from your private health records. It also explains your rights and our responsibilities.

Who Follows The Terms of This Notice

- Any health care provider who treats you at any of our locations
All employees, volunteers, and staff at the hospital and clinics
Healthcare students in training programs
Any business associate who performs work for us that requires them to see your medical information to do their jobs

Acknowledgement of Receipt

I understand that, as allowed and required by law, Denver Health staff will use and give out my health records, without my consent or authorization, for:

- Treatment: Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
Payment: Denver Health will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
Healthcare Operations: Denver Health will use my health records to run the hospital and clinics and to make sure patients receive quality care.

Otherwise, Denver Health will follow the restrictions in this Notice of Privacy Practices.

I acknowledge that I have received a copy of Denver Health's Notice of Privacy Practices.

Patient/Legal Representative

Date

Legal Representative's Relationship

Witness

Date

DENVER HEALTH AND HOSPITAL AUTHORITY

OUTPATIENT GENERAL CONSENT FOR TREATMENT AND TERMS RELATING TO PAYMENT (“CONSENT”)

CHANGES TO THIS CONSENT: I UNDERSTAND THAT I MAY NOT CROSS OUT ANY OF THE PROVISIONS OF THIS CONSENT AND THAT IF I DO THE DENVER HEALTH AND HOSPITAL AUTHORITY MAY REFUSE TO PROVIDE ME WITH NON-EMERGENCY-RELATED HEALTHCARE. I UNDERSTAND THAT ANY CHANGES I MAKE WILL NOT BE BINDING OR ENFORCEABLE.

DEFINITIONS: The “Denver Health and Hospital Authority” (“DHHA”) includes all of DHHA’s facilities including the hospital and neighborhood, school-based and mobile clinics and satellite offices and ambulances. “Healthcare” includes routine hospital services, diagnostic procedures, intravenous therapy, medications, anesthesia, injections, blood transfusions, counseling and other health services.

CONSENT FOR TREATMENT: I request and agree to receive healthcare from DHHA’s care providers and others allowed to provide healthcare at DHHA, either in person or via telehealth. DHHA is a teaching hospital and some of my care may be given by care providers in training who may not be employees of DHHA. I have a right to ask questions and talk about my treatment with my care provider and I have a right to refuse any treatment. If I decide to leave DHHA before my treatment is finished, I will talk to my care provider(s) before leaving. If I leave without talking to my care provider and my health, safety or welfare are not at risk, my leaving will be noted as a Discharge Against Medical Advice in the DHHA’s records. I may be asked to sign other consent forms if I have a procedure or take part in a research study. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and even death. I acknowledge that no guarantees or promises have been made to me about the outcome of my treatment.

IMAGES AND OBSERVATION BY OTHERS: My care providers may wish to have photographic, videotape, digital and other images taken of me for diagnostic, treatment, identification and educational purposes. Images that identify me will not be released outside of DHHA without my written permission, unless required by law or court order. I have a right to tell my care providers that I do not wish to have photographic, videotape, digital or other images taken of me. Care providers in training, who are not providing my care, may wish to observe my care for training and educational purposes. I have a right to tell my care providers that I do not wish to have others observe my care for training and educational purposes.

DISCLOSURE OF INFORMATION: I agree to allow DHHA and my care providers to disclose information from my medical and billing records for treatment, payment and healthcare operations purposes, as described in DHHA’s Notice of Privacy Practices, and for discharge planning, transfer and follow-up purposes. I agree to allow DHHA and my care providers to disclose information from my medical and billing records to any care provider involved in my care and to any party that may be responsible for payment of my healthcare expenses, including insurance companies, financial aid programs (“aid programs”), employers in workers’ compensation matters, and the party that caused my injuries and its legal representatives and insurers. I understand that once such information is disclosed, DHHA cannot control its confidentiality.

HEALTH INSURANCE AND FINANCIAL AID PROGRAMS: I understand that there is no guarantee of payment of my healthcare expenses by insurance or an aid program and that I must pay any healthcare expenses that are not paid by insurance or an aid program. I agree to give DHHA, prior to or at the time of my treatment, any information I have about any insurance available to pay my healthcare expenses and about any party that caused my injuries. I certify that all of the information I provide when applying for benefits under federal and state medical assistance programs will be true and correct. I understand that I must obtain all of the pre-authorizations and referrals required by insurance companies and aid programs in order to make payment of my healthcare expenses. I UNDERSTAND THAT I MUST PAY ANY HEALTHCARE EXPENSES THAT ARE NOT PAID BY INSURANCE OR AN AID PROGRAM BECAUSE I FAILED TO TIMELY PROVIDE DHHA WITH INFORMATION NECESSARY TO FILE A CLAIM, OR BECAUSE I FAILED TO OBTAIN NECESSARY PRE-AUTHORIZATIONS AND REFERRALS, OR BECAUSE DHHA IS AN OUT-OF-NETWORK PROVIDER. I agree to pay all co-payments, deductibles and other charges not covered by insurance or an aid program, unless payment is not required by law or written agreement. I understand that I must pay for any healthcare not covered or discounted by insurance or an aid program because the healthcare involves cosmetic or other elective surgery or care that is not deemed medically necessary.

ASSIGNMENT OF BENEFITS AND CLAIMS: I hereby assign to DHHA, up to the amount of my medical expenses, any and all benefits, damages and settlements that I may be entitled to receive from health, homeowner’s, business owner’s, workers’ compensation, rehabilitation and disability insurance; and from motor vehicle medical payment, liability, uninsured, underinsured, fault-based and personal injury protection insurance; and from any negligence, personal injury and breach of contract claims that I may have relating to my injuries; and from Medicare, Medicaid and other aid programs. I hereby give to DHHA the right to file claims with, and collect payments directly from, any insurance company, aid program, or party that caused my injuries; and I hereby order and direct such insurance companies, aid programs and liable parties to make payment directly to, and solely to the order of, DHHA. I hereby assign to DHHA any and all claims that I may have against any party that caused my injuries and that party’s insurers. DHHA may, in its sole discretion, file suit to recover my healthcare expenses in my name or in the name of DHHA. I agree to assist DHHA in pursuing its claim in any reasonable manner requested. I hereby give to DHHA an irrevocable, limited, power of attorney to sign on my behalf any release, consent, authorization or other document requested by an insurance company in order to make payment to DHHA. I wish to provide for the payment of my healthcare expenses in the event of my death and therefore, to the extent permitted by law, authorize DHHA to nominate a Personal Representative to file and administer my estate, provide for the payment of allowed claims and other obligations, and pursue any claims my estate may have against any party that caused my injuries and that party’s insurers for the recovery of my healthcare expenses. Article 27 of Title 38, of the Colorado Revised Statutes, permits DHHA to file hospital liens against any insurance proceeds available to pay my healthcare expenses. DHHA may include my name, social security number, and date of birth in any hospital liens that DHHA files on my account.

DELINQUENT ACCOUNTS: I understand that no extensions, leniency or delays by DHHA in enforcing its rights to collect my healthcare expenses will release me from my obligation to pay my healthcare expenses. If my balance owing to DHHA becomes delinquent, DHHA may refuse to provide me, where allowable by law, with non-emergency-related healthcare until my balance is fully paid. Interest on delinquent balances will be charged at the lower of 12% per annum or the highest rate allowed by law. Should it become necessary for DHHA to file a collection lawsuit against me, DHHA may file such lawsuit in the District or County Courts of Denver, Colorado. I agree that DHHA may submit, and testify as to, my medical and billing records in any such collection lawsuit and related mediation and discovery proceedings. In the event that DHHA prevails in court, I agree to pay to DHHA its reasonable attorney’s fees, court costs, and expenses of collection. I authorize DHHA to obtain copies of my credit bureau reports and to obtain from any source any and all information about me that is reasonably necessary for collection, location and identification verification purposes. I consent to be contacted by regular mail, email, text, or telephone (including wireless/cell number) regarding any matter to my account(s). This consent applies to all DHHA healthcare providers and/or any entity working on behalf of DHHA. This consent includes any updated or additional contact information that I may provide, and includes phone call that employ auto-dialer technology and prerecorded messages. If I wish to revoke this consent, I agree to provide notice of that revocation by contacting DHHA Patient Financial Services.

BEHAVIOR EXPECTATIONS: I understand that if I am physically or verbally threatening, hostile, or violent while at any DHHA facility, I may be refused any further non-emergency-related healthcare. I understand that DHHA Security and the Police will be called and that, if appropriate, I will be prosecuted. I also understand that while admitted for treatment to Denver Health I may not leave my hospital room to go outside.

NON-SMOKING POLICY: I understand that I am not allowed to smoke on or adjacent to the DHHA campus, nor can I leave the campus to smoke during my admission.

CONTRABAND AND PERSONAL VALUABLES: I understand that I may not keep any weapons, explosives, drugs, alcohol or other contraband while I am at any DHHA facility. Should DHHA suspect the presence of contraband, DHHA may search my clothing, personal belongings and area of care. If any contraband is found, DHHA may notify Law Enforcement and take possession of the contraband and dispose of it in any manner allowed by law. I understand that I should not keep in my possession any money or other valuable property while at DHHA. DHHA does not assume any responsibility for damage to, theft, or loss of my money and other property.

GOVERNMENTAL IMMUNITY: Medical care or treatment at DHHA may be provided by individuals who are considered public employees by the Colorado Governmental Immunity Act. The Colorado Governmental Immunity Act, Article 10 of Title 24 of the Colorado Revised Statutes, limits the amount of damages recoverable from public employees and entities, requires a formal notice of claim, and places a one hundred and eighty (180) day time limit on the period for filing such a notice of claim.

DURATION OF CONSENT: I understand that this Consent will remain in effect for as long as I receive healthcare at DHHA, or until I cancel this Consent in writing. If I cancel this Consent, it will be cancelled only as to future healthcare and not as to healthcare previously provided. If I have already received healthcare but my condition or other circumstances prevented me from signing this Consent until now, I understand and agree that the provisions of this Consent will apply to the healthcare that I have already received. I may be asked to sign additional Consent forms on a yearly basis and upon each admission to the hospital.

AUTHORIZED REPRESENTATIVE/GUARANTOR: If I am not the patient and I sign this Consent as the patient's Authorized Representative, I hereby state that I have full legal authority to sign on behalf of the patient and I understand that DHHA is relying upon the truthfulness of this representation. I understand that both the patient and I will be fully bound by all of the provisions of this Consent. I understand that, by signing this Consent as an Authorized Representative, I GUARANTEE AND AGREE TO MAKE PAYMENT OF ALL OF THE PATIENT'S HEALTHCARE EXPENSES, and that if payment is not made, the patient and I will be subject to the remedies provided in the paragraph entitled, *Delinquent Accounts*, above.

RELEASE OF INFORMATION: I authorize the release of my medical information for treatment, payment, and health care purposes as defined in the DHHA Notice of Privacy Practices. I also understand that my health information will be exchanged electronically with other participating healthcare organizations and providers for continuity of care. I acknowledge that I can change my participation status, by requesting to "OPT OUT", at any time by writing to: Denver Health and Hospital, ATTN: Health Information Management Department MC0296, 301 W. 6th Avenue, Denver, CO 80204.

ACKNOWLEDGMENT: I acknowledge that I have read this Consent and understand and agree with what it says. Any questions that I had about this Consent have been answered. No one has forced me to sign this Consent against my will. I have either received or have been offered a copy of this Consent.

I HEREBY CERTIFY THAT THE INFORMATION I PROVIDE BELOW WILL BE TRUE AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE INFORMATION TO OBTAIN HOSPITAL ADMITTANCE OR CARE IS A CLASS 1 MISDEMEANOR PUNISHABLE UPON CONVICTION BY UP TO EIGHTEEN (18) MONTHS IMPRISONMENT OR A \$5,000.00 FINE OR BOTH (C.R.S., §§18-13-124 and 18-1.3-501). I UNDERSTAND THAT IF I PROVIDE FALSE, MISLEADING, OR INCOMPLETE INFORMATION AS TO MY IDENTITY OR RESIDENCE ADDRESS OR WHEN APPLYING FOR A FINANCIAL AID PROGRAM, DHHA MAY REPORT ME TO LAW ENFORCEMENT AND MAY REFUSE TO PROVIDE ME WITH NON-EMERGENCY-RELATED HEALTHCARE.

If you are signing this Consent as the patient's Authorized Representative, put an "X" in the box that shows your legal relationship to the patient:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> patient's parent | <input type="checkbox"/> patient's stepparent | <input type="checkbox"/> patient's foster parent | <input type="checkbox"/> patient's spouse |
| <input type="checkbox"/> patient's legal guardian | <input type="checkbox"/> patient's legal custodian | <input type="checkbox"/> patient's conservator | <input type="checkbox"/> power of attorney |
| <input type="checkbox"/> patient's child over the age of 18 | <input type="checkbox"/> other legal relationship: _____ | | |

Patient Signature/ Date (mm/dd/yy) Time (00:00)

Print full legal name of Patient: _____

Authorized Representative Signature/ Date (mm/dd/yy) Time (00:00)

Print full legal name of Authorized Representative: _____

DHHA Witness Signature/ Date (mm/dd/yy) Time (00:00)

PRINT name of DHHA witness: _____

OFFICE USE ONLY:

- Patient is unable to provide consent due to condition.
- Patient is unable to sign due to condition; however, did provide Oral consent.
- Patient is a minor. Consent was obtained by telephone from _____, who is the patient's: _____.
- Patient refused to sign.

DHHA Staff Person's Name (Printed)

