LAH Consent to Treat Form

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to the following:

• I authorize LAH to perform an examination at the school clinic or via Telemedicine, and I understand that no guarantee has been made as to the results of such examinations and treatments.

• I consent to receiving over the counter medications (Tums, Ibuprofen, Tylenol), as needed for any acute illnesses diagnosed in the clinic.

• I consent to receive prescription medications per diagnosis and treatment of my illness. These medications are either e scribed to your pharmacy of choice or filled by Med-Pro Pharmacy (if applicable) and delivered to school by end of day.

• I consent to receive clearance for participation in sports, state-mandated hearing and vision screenings and infection control vaccinations (ex. influenza) through the school clinic.

• I give LAH permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

• I authorize LAH in conjunction with my school and any of its certificated staff to communicate and share information to assist LAH in treatment, including but not limited to my family and emergency contact information, attendance records and disciplinary information, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and any health conditions such as seizures or asthma.

• I authorize LAH staff members to release any medical records required by the insurer or other payer to obtain payment. Following applicable legal requirements, LAH staff members may use and share my medical information for: 1) treatment of my health condition and maintaining the continuity of my care, 2) payment for health services provided, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. A Notice of Privacy Practices document is available to me at the school clinic and on the LAH website.

• In order to enhance patient's care and experience, LAH may contact you after your visit in order to request feedback on your experience by phone call, SMS text message, e-mail, voicemail, or mobile application, some of which may be via automated means. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

• This Consent is valid for as I am employed by a school in contract with LAH or my child is enrolled in a school in contract with LAH.

• I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Revocation
I understand that this Consent Form may be revoked in writing at any time and that the revocation will take effect on the day it is received by LAH at the school clinic. The revocation must be in writing and signed by the patient, if over the age of 18, or the child's legal guardian. The revocation will not be effective to the extent that Requester or others have acted in reliance on this Consent Form.

Acknowledgment
I have carefully read the foregoing Consent To Treat/HIPAA form and fully understand the meaning of this consent. I affirm that I have signed this authorization voluntarily.

By signing this consent, I confirm I am the over the age of 18 or I am the parent/legal guardian of the minor listed below and am authorized to give this consent. I also provide authorization to disclose pertinent information among medical, behavioral and social service staff in order to provide comprehensive care.

I have read and agreed to the terms of the Medical Consent/HIPAA waiver. ☐ Yes ☐ No

Signature _______________ Date _______________

Print name _______________ Print student's name (if applicable) _______________