

Duval County Public Schools
Parent Permission For Dental Service

BOTH SIDES OF THIS FORM MUST BE COMPLETED

Dear Parent:

Your child's school will soon be visited by the mobile Children's Dental Unit as a joint effort of the Duval County Public Schools and the Duval County Health Department, to provide dental services for students. Kindergarten, first, second, third and fourth grade students on the free and reduced lunch program are eligible for the services. Limited dental examinations, cleanings, and sealants(protective coating on the chewing surface of the back teeth) to help protect the teeth against decay will be available to these students, at no cost to parents. Permission is required from one parent or guardian.

IF YOU DO NOT HAVE A PRIVATE DENTIST, AND YOU WOULD LIKE FOR YOUR CHILD TO TO RECEIVE THESE SERVICES, PLEASE COMPLETE, SIGN, AND RETURN THIS FORM TO YOUR CHILD'S TEACHER IMMEDIATELY. Parents do not have to be present when the services are provided. You will be notified if further treatment is required. Your child will not be given any sedatives or other medications.

PLEASE PRINT

Yes, I give permission for my child to receive dental services offered by the Children's Dental Unit. I understand that these dental services are being provided by the Duval County Health Department and not by the Duval County Schools and that my child may require dental care in addition to that provided by the DCHD dental bus.

School _____

Name of Child _____ Age _____
(Last) (First) (Initial)

Date of Birth _____ Sex _____ Medicaid # (if any) _____
(Month) (Day) (Year)

Child's Social Security # _____

Teacher _____ Grade _____

Parent or Guardian _____

Parent's Address _____ Zip Code _____

Parent's Phone Number(s) Home _____ Work _____

Signature of Parent or Guardian _____ Date _____

IMPORTANT: The health history information on the reverse side of this form must be completed and the medical release on the reverse side must be signed or treatment cannot be provided.

(OVER)

HEALTH HISTORY

- **Has your child ever been seriously ill?** Yes () No ()
If yes, please list all serious illnesses:
- **Has your child ever had rheumatic fever?** Yes () No ()
- **Does your child have a heart murmur?** Yes () No ()
- **Has your child ever had a bad reaction to medicines?** Yes () No ()
If yes, please give reason:
- **Is your child under the care of a physician?** Yes () No ()
If yes, please give reason:
- **Does your child take any medications?** Yes () No ()
If yes, please give the reason:
- **Is your child allergic to anything?** Yes () No ()
If yes, what?
- **Has your child received a dental examination or dental treatment within the last year?** Yes () No ()
- **Is there anything else we should know about the health of your child?**

CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ do hereby consent to Duval County
(Name of client/legal representative)

Health Department, 515 West Sixth Street, Jacksonville, FL 32206 and any physician or health
(Name and address of Agency or Individual in possession of the record)

care provider or authorised agent, examining or treating me to use or disclose protected health information for treatment, payment or health care operations including release to any third party payer, any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, or case management information, including any information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE ABOVE AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature X _____ Date ____/____/____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY



Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at www.myflorida.com and will be available by email and at all Department of Health buildings.



Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual.

Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- ▶ Reporting abuse of children, adults, or disabled persons.
- ▶ Investigations related to a missing child.
- ▶ Internal investigations and audits by the department's divisions, bureaus, and offices.

- ▶ Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- ▶ Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- ▶ District medical examiner investigations.
- ▶ Research approved by the department.
- ▶ Court orders, warrants, or subpoenas.
- ▶ Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.



Individual Rights

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- ▶ Was not created by the department,
- ▶ Is not protected health information,
- ▶ Is by law not available for your inspection, or
- ▶ Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- ▶ Disclosures made to you.
- ▶ Disclosures to individuals involved with your care.
- ▶ Disclosures authorized by you.
- ▶ Disclosures made to carry out treatment, payment, and health care operations.
- ▶ Disclosures for public health.
- ▶ Disclosures for health professional regulatory purposes.
- ▶ Disclosures to report abuse of children, adults, or disabled.
- ▶ Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- ▶ Purposes of research, other than those you authorized in writing.
- ▶ Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective beginning April 14, 2003, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 65, No. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 67, No. 157 (August 14, 2002).

DH 150-741, 4/03; Stock Number: 5730-741-0150-0