PARK DUVALLE
COMMUNITY HEALTH CENTER

Other Information

When was the last time the student was seen by a doctor?

Doctors Name: _____ Reason: _____ Date:__/__/_____

Do you have concerns about Student's health? ☐No ☐Yes

Does Student drink alcohol? ☐No ☐Yes

Does Student smoke and/or use tobacco products? ☐No ☐Yes

Is student exposed to secondhand smoke. ☐No ☐Yes

Immunization Status

Is the Student up to date on immunizations? ☐No ☐Yes

Family Income

People in Household: _____ Annual Family Income $_____

_____

Park DuValle Community Health Center School Based Health

Assignment of Benefits/ Consent for Treatment

I consent to the customary test, minor surgical procedures, procedures that may be deemed necessary for treatment of my child's condition by members of the Medical Staff of Park DuValle Community Health Center. Consent is hereby given for such visits to the school health center for the purposes of examination, treatment, and procedures this claim. I also request payment of government benefits to the party who accepts assignment. I authorize payment of medical benefits to the supplier for services provided by PDCHC. I understand that I may be billed separately for services provided by clinic providers for treatment related services.

Authorize for Release of Medical Information

I Hereby authorize the release of medical information as necessary for settlement of this claim. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV related diagnosis information, if any, as may be contained in the clinic records. I understand that I have the authority to release the above reference medical records, as well as release of records to my child's primary care provider. Further, I release PDCHC and any related corporations or affiliates from any liability resulting from the release medical information regarding sexually transmitted disease, if applicable, to Third Party Payor pursuant to KRS 214.420

I have read the above and understand that items above as it applies to me. I verify I have received a Notice of Privacy Practices (45 CFR 164.520 (2) (ii) and Bill of Rights.

I hereby give permission for PDCHC to verify the above information and for the student's health care provider (as listed on this form) to release required medical records (immunization records, preventative health care exams, dental exams, vision exams, etc.) to PDCHC. I hereby give permission to PDCHC.

Phone: _____ Parent/Guardian's Email: _____

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Parent/Guardian Name (Please Print) **Parent/Guardian Signature** **Da**