Connecticut Institute For Communities, Inc. (CIFC)
Greater Danbury Community Health Center (GDCHC) NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE GREATER DANBURY COMMUNITY HEALTH CENTER ("GDCHC") MAY USE AND/OR DISCLOSE HEALTH INFORMATION ABOUT YOU, HOW YOU CAN ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

GDCHC's Commitment to Your Privacy

GDCHC is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain at GDCHC concerning your PHI. According to federal and state law, we must follow the terms of the Privacy Notice that we have in effect at the time. This Notice will take effect on August 1, 2013 and will remain in effect until it is amended or replaced by GDCHC.

GDCHC reserves the right to change its privacy practices as the law permits. GDCHC will amend this Notice to reflect any change(s) and make any new Notices available upon request. Any changes to our privacy practices will be effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of GDCHC's Notice of Privacy Practices at any time by contacting our Privacy & Security Officer, Daniel Labrecque, at (203) 743-9760 Ext. 3403, or via mail at 120 Main Street St. 4th fl, Danbury, CT 06810. You may also contact Mr. Labrecque with questions about this notice or to file a privacy/security complaint.

GDCHC WILL KEEP YOUR HEALTH INFORMATION CONFIDENTIAL, USING IT ONLY FOR THE FOLLOWING PURPOSES. PLEASE NOTE THAT THE FOLLOWING USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Treatment: While we are providing you with health care services, we may share your protected health information (PHI), including electronic protected health information (ePHI), with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, or data analysis. These business associates and subcontractors are required by Federal law to protect your health information. For example, we may ask you to have laboratory tests (such as blood or urine), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may disclose your PHI to a pharmacy when we order a prescription for you. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Additionally, everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your PHI to seek payment for services we provide to you. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatments. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, to evaluate the implementation of our compliance programs, and/or to conduct cost-management or business planning activities.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

NOTE: This is an abbreviated version of GDCHC's Notice of Privacy Practices. The full notice lists: (1) additional ways GDCHC may use your health information; (2) situations when your authorization is required for release; and (3) your right regarding PHI. A full notice is available at all GDCHC sites. To receive a copy of the full and complete GDCHC Notice of Privacy Practices, please contact School Based Health Center Staff.

Reg#_____

Connecticut Institute for Communities, Inc. (CIFC) Greater Danbury Community Health Center (GDCHC)

School Based Health Centers Permission Form

All information on the front and back of this permission form must be completed, dated and signed before your child can receive services from the School Based Health Centers. If a student is 18 or older, he/she may sign his or her own permission form. *Race /* Ethnicity information is required by the State and will be used for statistical purposes only.

Student Name (Last, First, M.I.)	Date of Birth (month/day/year)	☐ Male ☐ Female ☐ Other _____	Grade/Cluster
Street Address (Street, Town, State, ZIP code)		Student's Cell Number	

Parent/Guardian Name		Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)		Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number		Work Phone Number

Parent/Guardian Name		Relationship to Student	Date of Birth
Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code)		Parent/Guardian E-Mail address	
Home Phone Number	Cell Phone Number		Work Phone Number

Emergency Contact Name		Relationship to Student
Home Phone Number	Cell Phone Number	Work Phone Number

***Race**: (Please check one) ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ More than one race ☐ Unreported / Refuse to Report		In what country was the student born?
***Ethnicity:** Hispanic/Latino? ☐YES or ☐ NO	What language(s) does the student speak? (*check all that apply*) ☐ English ☐ Spanish ☐ Portuguese ☐ Other: _____	Translator needed: ☐ YES or ☐ NO
Is the student on the free or reduced lunch program? ☐ YES or ☐ NO	Estimated Family Income $:	# of Family Members:

Medical Care		**Dental Care**	
Name of Doctor or Medical Clinic: *If No doctor, write "NONE" below*		Name of Dentist: *If No Dentist, write "NONE" below*	
Doctor's Address **(Street, Town, State, ZIP)**		Dentist's Address **(Street, Town, State, ZIP)**	
Doctor's Phone Number:	Date of last physical exam:	Dentist's Phone Number:	Date of last dental exam:

Pharmacy Name: _____ **Address:** _____ **Phone #:** _____

Does the student have **MEDICAID/Husky Insurance:** YES or NO
Medicaid Pending: YES or NO
****Please provide a copy of the insurance card**

If your child does not have health insurance
Please call 1-877-CT-HUSKY

Medicaid #: _____

Child's name on Card: _____

***If NO insurance, contact the SBHC for enrollment Assistance**

Does the student have **Private/Commercial Insurance:** YES or NO
****Please provide a copy of the insurance card**

Name of Insurance Company: _____
Policy Holders Name: _____
Policy Holders Date of Birth: _____
Policy Holders Address: _____
Policy Holders Employer: _____
Relationship to student: _____
Insurance Number for the student: _____
Group number: _____

Newtown Middle School SBHC (7:30am – 2:30 pm) Phone: (203) 270-6114 Fax: (203) 270-4644

****PLEASE ANSWER ALL QUESTIONS AND SIGN AND DATE PAGE 2****

SBHC Medical History Form (Page 2)

Student's Name: _____ **Date of birth:** _____

Is the student currently taking any medications? ☐ Yes ☐ No If YES, please list below including dosages and how often. (Include asthma inhalers and EpiPens)

_____
_____
_____
_____

Medical History: ***Please check all that apply and explain on the lines below:***

☐ Hospitalization or Surgery	☐ Fainting or Blacking-Out	☐ Concussions
☐ Allergies (food, medication, bees, etc.)	☐ Running / Exercise Problems	☐ History of Seizures
☐ Seasonal / Environmental Allergies	☐ Asthma / Breathing Issues	☐ Headaches / Migraines
☐ Broken bones, Dislocations	☐ Blood Disorders /Anemia / Sickle Cell	☐ Diabetes/Thyroid/Endocrine
☐ Muscle or Joint Injuries	☐ Vision Problems (Contacts / Glasses)	☐ Weight or Eating Issues
☐ Neck or Back Injuries	☐"Mono"	☐ Females: Menstrual problems
☐ Heart Defects / Murmurs	☐ TB or Positive Skin Test	☐ Stomach Problems
☐ High Blood Pressure / Cholesterol	☐ Skin Problems (Eczema, Psoriasis)	☐ Hearing Problems
☐ Chest Pain during or after exercise	☐ Dental Problems (Pain / Bleeding)	☐ Any other medical problems

Is the student under the care of any medical specialist? ☐ Yes ☐ No

Has student seen a dentist within the last year? ☐ Yes ☐ No Has student seen same dentist for more than one year? ☐ Yes ☐ No

_____
_____
_____

Mental Health History: ***Please check all that apply and explain on the lines below:***

☐ Mood Disorder / Depression	☐ Learning Disorder / ADD / ADHD / Autism Spectrum
☐ Anxiety / Panic / OCD	☐ Loss / Divorce / Deportation of family members
☐ Anger / Other Behavioral Issues	☐ Substance use / Vaping
☐ Academic Concerns	☐ Eating / Significant Weight loss or gain
☐ Cutting / Self-harm	☐ Other unlisted concerns

_____
_____
_____

Family History: ***Please check all that apply and explain which family members they apply too on the lines below:***

☐ Family member with heart disease	☐ Family member with mental illness (i.e. depression)
☐ Family member with high cholesterol	☐ Family members with alcohol / drug problems
☐ Family member with diabetes	☐ Family medical problems not addressed above

☐ Has any sudden family member died of heart problems or sudden death before age 50? ☐ Yes ☐ No

PLEASE SPECIFY WHICH FAMILY MEMBER (Maternal / Paternal): _____
_____
_____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

I have read the information regarding the CIFC GDCHC School Based Health Center and I give permission for this student to obtain all services offered at the School Based Health Center while he/she is enrolled in school. I understand that services are confidential, except in life-threatening situation or emergency services and accordance with the law. I give permission to the CIFC GDCHC School Based Health Centers and the Newtown Public Schools to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing. I authorize payments to be made directly to the CIFC GDCHC School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the CIFC GDCHC's privacy policy as per federal law. ***Unless I choose to withdraw my consent in writing, this authorization for services at the School Based Health Centers will continue for the entire period of time this student is enrolled in Newtown Public Schools.***

Date:_____ **Signature:**_____ **Relationship to student:**_____