

**WASHINGTON COUNTY HEALTH DEPARTMENT**

**SCHOOL BASED WELLNESS PROGRAM**

**CONSENT FOR RELEASE OF PATIENT INFORMATION**

for treatment, payment and health care operations

When you sign this form, you understand that Washington County Health Department School-Based Wellness Center will be using and releasing your health information. The release of health information would be for purpose of treatment, payment and health care operations. Treatment includes release of protected health information to referred specialist.

We have given you a copy of our **Notice of Privacy Practices**. It provides more detailed information about how we may use and release your protected health information. We encourage you to read it in full. Your signature on this form acknowledges that you have been given a copy of the **Notice of Privacy Practice**.

You have the right to cancel this agreement in writing. This would not include information we had already used or released prior to the cancellation.

Please Initial

I give Washington County School-Based Wellness Center permission to call my house with health care information.

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I give Washington County School-Based Wellness Center permission to leave a message with health care information on an answering machine or with a person at my home.

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I give Washington County School-Based Wellness Center permission to mail health care information to my house.

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I request to receive communications from Washington County School-Based Wellness center as follows:

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\_\_\_\_\_

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I give permission for School-Based Wellness Center staff to obtain/review School Health records and allow School Health staff to obtain/review School-Based Wellness center records.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Patient Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_