Zumbro Valley Health Center
Parent/Guardian Consent Form

Zumbro Valley Health Services will offer mental health care to students at Kingsland School District. Services will include care for a variety of mental health needs, along with the provision of chemical dependency evaluations. Services will be provided in individual, group, and family formats, depending on the student's individual needs.

If a student has insurance coverage, a claim may be generated for the service that is provided at Kingsland School District. If a referral is made for more intensive services at Zumbro Valley Health Center offices, the student and parent will be required to do a formal intake with the Customer Service staff to initiate services.

In order for your child to receive mental and chemical health care from the Zumbro Valley Health therapist, the following form must be completed and signed.

Per MN statute 144.343, a minor may give consent for medical, mental, and other health services to determine the presence of or to treat pregnancy, and conditions associated with venereal disease, and alcohol and other drug abuse.

Name_____ Date of Birth _____Male ☐ Female ☐

Address_____

Phone Numbers_____

School ID Number_____

Grade_____ Primary Clinic/Health Care Provider_____

By signing this form you indicated an understanding that:

- Kingsland School District may give information about the student's health status (including access to school health records) as well as information about class schedule and attendance record to ZVHC personnel.
- ZVHC personnel may exchange health information with the Kingsland School staff and with other health care providers to whom the student may be referred for care, including but not limited to Mayo Clinic, Olmsted Medical Center and Rochester Students' Health Services. All health information will be handled in a strictly confidential basis and in accordance with Minnesota data privacy laws.

- One limit to confidentiality is if a student discloses information that would indicate an imminent danger to self or others. Additionally, if the student shares information pertaining to abuse or neglect, ZVHC staff is mandated to report the information to the Common Entry Point for abuse reporting.
- Kingsland School District and Zumbro Valley Health Center may use student health records (while protecting student confidentiality) to evaluate the quality of care provided by Zumbro Valley Health Center.
- A photocopy of this form is considered as valid as the original.
- Permission will remain in effect until changed in writing by you or until the child reaches 18 years of age.

Please sign below if you have read and understood the information provided on this form.

Signature:_____ **Relationship to child:_____**

Date:_____ **Daytime phone:_____**

If you have questions about this form or about the mental health services provided by Zumbro Valley Health Center please contact the Zumbro Valley Health Center main office at (507) 289-2089.

ZUMBRO VALLEY HEALTH CENTER

Demographic/Financial Information

Thank you for your inquiry regarding Zumbro Valley Health Center Psychotherapy through Kingsland SLMH (School-Linked Mental Health) services. Psychotherapy services are typically covered through health insurance companies. To get your child started in services, please complete the following form and return to the school office or call Zumbro Valley Health Center's main office at 507-289-2089 and request intake.

School (check one): ☐ Elementary School ☐ Middle/High School

Child's Name: _____

DOB: _____

Social Security: _____

Address: _____

County of Residence: _____

Annual Household Income: _____

Number of persons in household: _____

Individuals under 18 in household: _____

Parent Name or Contact Person: _____

Phone Number of Contact Person: _____

Insurance Carrier & ID Number: _____

Cardholder's Name: _____

Cardholder's Date of Birth: _____

Secondary Insurance Carrier & ID Number (if applicable):_____

Secondary Cardholder's Name: _____

Secondary Cardholder's Date of Birth: _____

Child's Name (if different from cardholder):_____

Zumbro Valley Health Center and Kingsland Schools
School Based Mental Health Form

Date	

Student's Name			
Grade		Teacher	

Referral Source ☐ Teacher ☐ Counselor ☐ Staff ☐ Parent

Reason for Referral:

☐ Anxious/Nervous	☐ Distressing Memories	☐ Worries Often	
☐ Ashamed/Guilt	☐ Lose Temper	☐ Loss	☐ Irritability/Angry
☐ Cry Easily/Often	☐ Trauma	☐ Perfection	☐ Bullies Others
☐ Depressed/Sad	☐ Low Self-Esteem	☐ Sleep Problems	☐ Social Discomfort

Other comments/concerns:

Authorization for Release of Information

Section I. [1]

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

Date of Birth: _____ (mm/dd/yy) **ID:** _____ **Grade:**_____

School:_____

Section II [2]

Parent/Guardian Name: _____

Authorizes: Kingsland School District _____ _____
District Name / Number Staff Person Responsible

_____ _____
School Responsible Address

☒ to release the specific information identified below ***to***:

☒ to obtain specific information identified below ***from***:

Name of individual or entity, Title: _____ Organization: Zumbro Valley Health Center _____

Address: _____

☒ Health Records	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Medical Reports	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Chemical Abuse/ Dependency Report	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Psychological Reports	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Psychiatric Report	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Teacher, Counselor, Staff Observations	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Special Education Records	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Social Work Report	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)
☒ Others *(specify)* SLMH Grant Funding Info	Created between _____ (mm/dd/yy) and _____ (mm/dd/yy)

For the purpose of :

Coordination of Services and Referrals

_____

_____

Section III [3]

I understand this authorization:

- takes effect the day I sign it,
- cannot exceed one year, and expires either:
  - ☐ on _____ (mm/dd/yy), or
  - ☐ one year from the date of my signature,
- can be stopped any time by sending a written request to:

_____

_____

_____

_____

I further understand:

- I may refuse to sign this authorization and it will not affect my child's ability to receive educational services,
- the laws that protect the information identified on this release, in some situations, may allow or require this entity to re-disclose this information, but only as permitted by law Health Insurance Portability and Accountability Act [HIPAA], Family Educational Rights & Privacy Act [FERPA], Minnesota Government Data Practices Act [MGDPA or Chapter 13]),
- a copy of this release form is as valid as an original, and
- I will receive a copy of this authorization.

Signature: _____ **Date:**_____
Parent, legal representative or student (mm/dd/yy)

References to regulations [4]

MDE -06/14/06

Authorization for Use and Disclosure of Protected Health Information

INSTRUCTIONS TO CLIENT OR THEIR PERSONAL REPRESENTATIVE: 1. Make sure all fields on this form are filled in. 2. Sign and date this form only if you believe the use and disclosure of information is in your best interest.

Client name: _____ _____
Last First M.I. Date of birth

Other name(s) or identifying information under which personal health information (PHI) may be logged:

_____

I hereby authorize: Zumbro Valley Health Center, 343 Wood Lake Drive SE, Rochester, MN 55904 to:

☒ Exchange with: ☒ Disclose to: ☒ Obtain from:

Facility name: MN Department of Health and Human Services

Valid For: ☐ **Specific Time Period** ☐ **One Year** ☒ **Unlimited Time***

***I understand that by choosing the unlimited option that this Release of Information will not expire unless otherwise revoked by myself.**

Please indicate the time period for which you are requesting records.

If no specific date(s) are provided, only the most recent documents(s) will be released for items that are checked.

Requesting records from this date: _____ **Requesting records to this date:** _____

- ☐ Diagnostic assessment
- ☐ Lab results
- ☐ Medication history
- ☐ Alcohol/drug treatment records
- ☐ Alcohol/drug assessment
- ☐ All information collected for state medical review team
- ☐ Primary care provider notes
- ☒ Other: SLMH Grant Funding Information for State Data
- ☐ Psychological/psychiatric evaluation
- ☐ Therapy/counseling session notes
- ☐ Discharge/treatment summary
- ☐ Medication management notes
- ☐ Treatment plan
- ☐ Information about eligibility for MN Healthcare programs
- ☐ Legal documents

For the following purpose:

- ☐ Determination of disability
- ☐ Social Service involvement
- ☐ At the request of the client
- ☐ Emergency contact
- ☒ Billing
- ☐ Other: _____
- ☐ Coordination of care
- ☐ Court ordered
- ☐ Continued care/treatment planning
- ☐ Determine eligibility for healthcare benefits

Private Health Information (PHI) includes both written and oral information. Do you give your permission for the facility or individual to speak with ZVHC staff: ☒ Yes ☐ No

I understand that I have the right to revoke this authorization. If Zumbro Valley Health Center has already released information based on this consent, we cannot retrieve what has already been released.

I recognize that the protected health information used or disclosed according to this authorization may be re-disclosed by the recipient and ZVHC can no longer protect it.

I understand that the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, and HIV/AIDS.

I understand that I will not be denied services by ZVHC or its providers based on whether or not I sign this authorization.

_____ _____ _____
Client signature Date Witness signature

_____ _____ _____
Parent, guardian or authorized signature Date Relationship to client