

## **Zumbro Valley Health Center Parent/Guardian Consent Form**

Zumbro Valley Health Services will offer mental health care to students at the Pine Island Elementary and 5-12 Schools. 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 the Pine Island Elementary and 5-12 Schools. 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:

- Pine Island 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 Pine Island Elementary and/or 5-12 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.
- Pine Island 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.**



## Demographic/Financial Information

Thank you for your inquiry regarding Zumbro Valley Health Center Psychotherapy through Pine Island 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): \_\_\_\_\_



**Pine Island Public Schools**  
**CONSENT TO RELEASE PRIVATE DATA**

Parent(s), this form allows information about your child to be exchanged. Please sign and return to the school.  
(address below)

Learner's Full Name: \_\_\_\_\_

ID \_\_\_\_\_ Birthdate \_\_\_\_\_

Month/Day/Year \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Address: \_\_\_\_\_

I authorize \_\_\_\_\_ District # \_\_\_\_\_

*School district name and person responsible*

*Address*

*City*

*State*

*Zipcode*

- to release information to: (check either or both boxes, as needed)  
 to obtain information from:

*Name, Title*

*Organization*

*Address*

*City*

*State*

*Zipcode*

School records may be examined by parent(s), or learner if of legal age. *The information to be released:*

\_\_\_\_\_ Official School Records (name, address, birthdate, sex, attendance record, grade level, grades, class rank, standardized group test results)

\_\_\_\_\_ Health Record

\_\_\_\_\_ Chemical Abuse/Dependency Report

\_\_\_\_\_ Psychological Reports

\_\_\_\_\_ Medical Report (including related services)

\_\_\_\_\_ Special Education Records (including related services)

\_\_\_\_\_ Psychiatric Report

\_\_\_\_\_ Teacher, Counselor, Staff Observations

\_\_\_\_\_ Social Work Report

\_\_\_\_\_ Others (specify) \_\_\_\_\_

\_\_\_\_\_ Others (specify) \_\_\_\_\_

The purpose for the request: \_\_\_\_\_

I understand that this authorization takes effect the day that I sign it. It expires on \_\_\_\_\_ (Month, Day, Year) or no more than one year from the date of my signature. I also understand that I may change this authorization at any time.

Month/Day/Year \_\_\_\_\_

Parent Signature (or Learner, if of legal age)



# 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: \_\_\_\_\_

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: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Diagnostic assessment                                   | <input type="checkbox"/> Psychological/psychiatric evaluation                     |
| <input type="checkbox"/> Lab results   | <input type="checkbox"/> Therapy/counseling session notes                         |
| <input type="checkbox"/> Medication history                                      | <input type="checkbox"/> Discharge/treatment summary                              |
| <input type="checkbox"/> Alcohol/drug treatment records                          | <input type="checkbox"/> Medication management notes                              |
| <input type="checkbox"/> Alcohol/drug assessment                                 | <input type="checkbox"/> Treatment plan   |
| <input type="checkbox"/> All information collected for state medical review team | <input type="checkbox"/> Information about eligibility for MN Healthcare programs |
| <input type="checkbox"/> Primary care provider notes                             | <input type="checkbox"/> Legal documents  |
| <input type="checkbox"/> Other: _____  |   |

For the following purpose:

- |   |  |
|---|--|
| <input type="checkbox"/> Determination of disability  | <input type="checkbox"/> Coordination of care                          |
| <input type="checkbox"/> Social Service involvement   | <input type="checkbox"/> Court ordered                                 |
| <input type="checkbox"/> At the request of the client | <input type="checkbox"/> Continued care/treatment planning             |
| <input type="checkbox"/> Emergency contact            | <input type="checkbox"/> Determine eligibility for healthcare benefits |
| <input type="checkbox"/> Billing                      |  |
| <input type="checkbox"/> Other: _____                 |  |

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

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