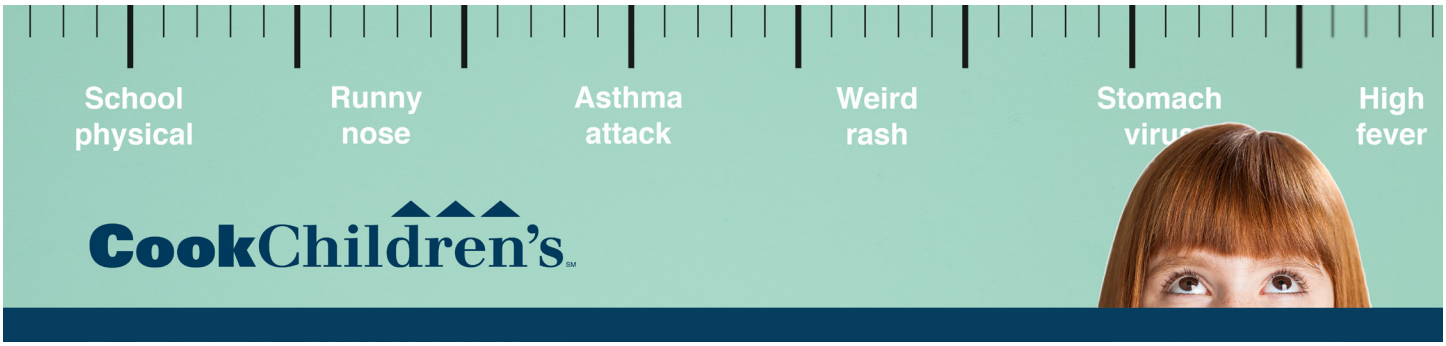

Cook Children's is with you every inch of the way ...

Even when your child is sick at school.

Patient registration packet

Cook Children's Telehealth and Virtual Medicine program

We are always here when you need us.

Cook Children's School Based Telemedicine Program

Cook Children's Physician Network is excited to be working with your child's school district to offer parents and students a new option for pediatric care. Through high definition telemedicine video and communications equipment, the school nurse can connect with a Cook Children's pediatric provider for quick assessment and treatment to care for your child while at school.

How does the program work?

With the parent's permission, a student may be evaluated by a board certified pediatrician or certified nurse practitioner through a telemedicine conference. The school nurse will quickly evaluate the student in person. With the parent's permission, the school nurse can connect with a Cook Children's pediatrician or nurse practitioner. The Cook Children's provider will complete an assessment of the student to include input from the school nurse and participating parent or legal guardian during the visit.

The school nurse will assist the provider during the evaluation through the use of special equipment as needed. The provider can hear the student's heart and lungs with a digital stethoscope. The provider can closely examine the student's ears, throat, rash, or abrasions with a high definition camera.

Upon completion of the evaluation, the provider will give instructions for follow-up care and submit an order to your pharmacy of choice for prescription medications, if needed. A record of your child's visit will be kept in the student's medical record at Cook Children's for future reference. A copy of the visit summary will also be sent to your child's primary care physician. The parent or legal guardian will have access to all treatment information through the Cook Children's online health record portal.

What are examples of conditions that could be treated?

Examples of conditions that could be treated by telemedicine are:

- Earaches
- Fever
- Coughs and colds
- Rashes and minor skin infections
- Abrasions and scrapes
- Strep throat and Influenza
- Headaches
- Pinkeye

There are medical needs that will require an in person evaluation by a medical provider. You may be asked to schedule an appointment with your child's primary care physician directly if evaluation by telemedicine isn't sufficient for diagnosis.

How do I enroll my child for the program?

You can register electronically using this online link http://www.schooltelemed.org or you can complete a paper packet (available at your school nurse's office) and return to your child's school. They will submit all required documentation to Cook Children's to enroll your child in the program.

How is the program funded?

Physician/nurse practitioner services are provided on a fee for service basis. Insurance and Texas Medicaid will be billed for those students presenting verified coverage. When eligible coverage cannot be verified, the parent/guardian will be asked for payment. Payments can be made online after your child's visit by accessing your child's Cook Children's health record portal account.

The current cash fees are:

New Patient Evaluation = $65
Established Patient Evaluation = $50
Rapid Strep Test = $13
Rapid Flu Test = $20

A new patient is defined as a patient that does not have an established relationship with a Cook Children's Physician Network pediatrician. Point of service testing or other services ordered by the physician during the visit will result in an additional fee per service.

A current list of Cook Children's Physician Network physicians can be found at www.CookChildrens.org

How do I register to see my child's visit summary in the health care portal?
Once registration into the program is completed for your child, you will receive an email invitation to the email address listed on your child's registration form that includes a link to set up your Cook Children's portal account.

How will I know if my child has a scheduled telemedicine appointment?
When a student presents to the school nurse's office, the nurse will assess the student's condition and contact the parent or legal guardian to discuss if it is appropriate to schedule an appointment. An appointment cannot be scheduled without the consent of the parent or legal guardian.

How can I participate in my child's appointment?
You may participate in your child's appointment in three different ways. The provider may ask you about your child's medical history or current medications so please have this information ready and available.

1) You may attend the appointment in person at your child's school.
2) You may listen to your child's appointment by phone call.
3) You may request an email link sent to you to join the appointment by video.

    a. Monitor your email queue closely and prepare to join the session promptly. The provider and nursing staff will be moving from student appointment to student appointment as close to the scheduled time as possible.
    b. Ensure that the camera and microphone on your device are turned on.
    c. Ensure that you are in a private and quiet location to protect your child's privacy and minimize background noise or distractions.

Who should I contact if I have questions?

Registration or Billing Questions – Please contact Cook Children's Telemedicine Services Coordinator at SchoolTelemed@cookchildrens.org or 682-885-3426.

Follow-up questions about my child's school based clinic visit – If you have questions regarding recommendations made for your child's care, medication questions, or to report a change in your child's condition, please contact your child's Cook Children's physician or the school based team at 682-885-3426.

Routine Healthcare Needs – Please contact your child's primary care physician for any routine healthcare checkups/vaccinations.

School Based Healthcare Needs – Please discuss any health care needs your child may have while at school directly with the school nurse at your child's campus.

Please return the following documentation to your school nurse:

1. **Registration Form**
   Demographic and insurance information for your child.

2. **Medical Consent to Treat**
   Authorizes a Cook Children's provider to evaluate and treat your child.

3. **Telemedicine Consent to Treat**
   Authorizes a Cook Children's provider to evaluate and treat your child by telemedicine.

4. **Acknowledgment of Privacy Practices/Financial Disclosure**
   Confirmation that you have received detailed information regarding Cook Children's policies about privacy practices and financial responsibility.

5. **Notice of Privacy Practices Brochure**
   Detailed brochure regarding Cook Children's privacy practices for parent/guardian to keep.

6. **Authorization to Release/Obtain PHI for School Based Telemedicine Services**
   Authorizes the exchange of certain health information between your child's school nurse and Cook Children's.

7. **Non-Parental Consent to Medical/Surgical Care and Treatment**
   Authorizes other adults who are not custodial parent or legal guardian to participate in decision making for your child's care (i.e, grandparent, step parent, nanny, etc.).

8. **Patient Information and Medical History Form**
   Medical history and general health information for your child that the Cook Children's provider will reference during your child's visit.

9. **Photo Copy of Insurance Card and Parent/Guardian Driver's License**
   Copies will be maintained in your child's medical record to reference as needed.

Revised 07/2017

Registration Form

DATE COMPLETED: _____

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First) _____ (MI)

DOB: _____ Age: _____ Sex: M _____ F_____

_____ (Primary Language Spoken) _____ (Race) SS#: _____

_____ (Address) _____ (City) _____ (State) _____ (Zip)

_____ (Student Grade) _____ (School ISD) _____ (School Campus)

_____ (Preferred Pharmacy Name) _____ (Phone Number)

PARENT/GUARANTOR INFORMATION

Name: _____ (Last) _____ (First) _____ (MI)

_____ (Address) _____ (City) _____ (State) _____ (Zip)

_____ (Relationship to Patient) DOB: _____ SS#: _____

_____ (Phone Number) _____ (Email Address (required for health portal registration))

EMERGENCY CONTACT INFORMATION

Name: _____ (Last) _____ (First) _____ (MI)

_____ (Relationship to Patient) _____ (Phone Number)

INSURANCE INFORMATION

_____ (Insurance Company Name) _____ (Policy Number) _____ (Group Number)

_____ (Policy Holder Name) _____ (Relationship to Patient) _____ (Employer)

DOB: _____ SS#: _____

revised 07/2017

COOK CHILDREN'S HEALTH CARE SYSTEM
CONSENT FOR TREATMENT

MEDICAL DENTAL AND SURGICAL CONSENT: By signing this form, I am consenting to any exams, X-rays, laboratory procedures, tests, medications, medical treatment, dental treatment, pictures, videos, and other services determined advisable for the patient by the attending doctor or other healthcare providers. Other healthcare providers could include other treating or consulting doctors, dentists, their associates, technical assistants, nurses, and other hospital staff.

This consent applies during the evaluation, diagnosis and treatment of the patient being cared for by Cook Children's Health Care System and its affiliated companies (also known as "CCHCS"). CCHCS companies include: Cook Children's Medical Center ("CCMC"), Cook Children's Physician Network, and Cook Children's Home Health.

I also consent to allow students (such as medical fellows, medical residents, medical students, student nurses and other authorized individuals that are enrolled in professional training programs) and physicians undergoing training to watch or join in the care provided as the treating doctors or dentists find appropriate, and as allowed by CCHCS policy.

I understand that no one can guarantee the results of any healthcare treatment. I agree that any tissue or body parts removed from the patient will be kept and disposed of by CCHCS according to its policies.

DOCTORS DENTISTS AND INDEPENDENT CONTRACTORS: Each patient within CCHCS is under the care of a doctor and/or dentist. Doctors and dentists are not always employees of CCHCS. Some doctors or dentists may be independent contractors. All doctors and dentists assume responsibility for the medical or dental care they provide.

ACCIDENTAL EXPOSURE TO THE HEALTHCARE WORKER: I understand that Texas law states that if any healthcare worker is exposed to a patient's blood or other bodily fluid, then CCHCS may perform test(s) for HIV (the "Human Immunodeficiency Virus") on that patient's blood or bodily fluid. I give consent to test for other diseases too, including hepatitis, syphilis, and others. I understand that these tests are necessary to protect healthcare workers who are caring for CCHCS patients.

PATIENT RIGHTS AND RESPONSIBILITIES: If I or my child is being admitted to CCMC, I will be given written information on the rights and responsibilities of the patient. This information tells me how to file a complaint or grievance if I have a problem with the care the patient receives during the hospital stay.

MONEY AND PERSONAL VALUABLES: CCHCS maintains a locked safe where I can store money and valuables. I understand that CCHCS will not be responsible for lost or damaged money or property unless those things are brought to the CCHCS safe and left there. I will be given a written receipt for them. I understand that I must have the receipt with me to get the things back out of the locked safe.

THE PERSON SIGNING THIS CONSENT FORM CERTIFIES THAT: 1) HE/SHE IS EITHER THE PATIENT, PARENT OF THE PATIENT, OR LEGALLY AUTHORIZED REPRESENTATIVE OF THE PATIENT; 2) HAS READ (OR HAS BEEN READ) THIS FORM AND UNDERSTANDS WHAT IT SAYS; AND 3) AGREES TO THE TERMS OF THIS CONSENT FORM.

Patient's Name Printed: _____ Date of Birth: _____

Patient/Parent/Legal Guardian Signature: _____ Date/Time: _____

Relationship to the Patient: _____

Witness: _____ Date/Time: _____

PRINT OR IMPRINT PATIENT INFORMATION

CADMIT

CookChildren's
801 Seventh Avenue
Fort Worth, Texas 76104-2796

(Rev. 11/15)

Cook Children's
Physician Network

TELEMEDICINE CONSENT AND ACKNOWLEDGEMENTS

CONSENT: I voluntarily request Doctor(s) of Cook Children's Physician Network and such associates, technical assistants and other health care providers as they may deem necessary ("Telemedicine Providers") to participate in my medical care through telemedicine and related remote communication software, devices and technologies. I understand that telemedicine includes interactive audio, video or other electronic media.

I understand that the Telemedicine Providers will sometimes be at a remote location while providing healthcare services for me, but their expertise and availability via technology has the potential to enhance the quality of healthcare services I may receive, if used appropriately and when medically necessary.

I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. It is also my responsibility to comply with instructions I receive from my health care providers and to report deviations from such instructions to my health care providers in a timely manner. I consent and authorize Telemedicine Providers to audio record, video record, and/or still photograph the visit as necessary for providing quality healthcare services via technology. I understand that all recordings, videos or images will become part of my medical record.

I understand that the use of technology for diagnosing or treating my health condition(s) presents certain risks, including but not limited to the following that may occur in rare instances:

- Transmitted information may be distorted or insufficient to allow for appropriate medical decisions;
- There may be unanticipated delays in diagnoses or treatments due to equipment or technology failure or deficiencies;
- Problems with Telemedicine Providers being able to access my complete medical records may result in adverse drug interactions, allergic reactions or other medical decision errors; and
- The use of technology to store and transmit my medical records introduces additional opportunities for someone to breach the security and privacy protocols intended by my Telemedicine Providers to otherwise protect my confidential information.

I understand that the during a telemedicine encounter the Telemedicine Providers may determine that telemedicine is not appropriate in a specific circumstance. If such occurs, the Telemedicine Provider will terminate the telemedicine encounter and advise me on where and how I may receive ongoing healthcare services in light of the circumstances. I understand that, in the event of any technological or equipment failure during a telemedicine encounter, I should call the following number [682-885-4000] for directions on rescheduling the telemedicine encounter or directions on how and where I may receive ongoing healthcare services appropriate for my condition.

At the end of each telemedicine encounter, I understand that my Telemedicine Provider will give me the contact information for the healthcare practitioner(s) who will be available to provide me with follow-up care in the event that I have any adverse or unexpected reactions to the telemedicine treatment recommendations. I understand that I have the right to withdraw this consent to the use of telemedicine at any time, without affecting my right to future care or treatment.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Signature of Patient/other Legally Authorized Person	Signature of Witness or Translator
Print Patient Name/ Or any other Legally Authorized Person	Print Name of Witness or Translator
Date Time	Translated Language (If not English)

COOK CHILDREN'S HEALTH CARE SYSTEM
ACKNOWLEDGMENT OF PRIVACY PRACTICES/FINANCIAL DISCLOSURE

I understand that I have the right to restrict how my Health Information (defined below) is used or disclosed by Cook Children's Health Care System and its affiliated companies (hereinafter collectively referred to as "CCHCS") to carry out treatment, payment, or health care operations. I may seek to restrict these uses or disclosures by designating my restrictions in writing, however, I understand that CCHCS is authorized by federal law to refuse to abide by my requested restrictions and that restrictions on use of Health Information for payment, treatment, or health care operations may prevent me from receiving medical Services at CCHCS.

RELEASE OF INFORMATION: I consent and authorize CCHCS and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at CCHCS or by any practitioner providing medical goods and services to the patient, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), Hepatitis A, B and C, drug/alcohol abuse and treatment, psychiatric diagnosis and treatment records and/or laboratory tests results, medical history, treatment progress, and/or other such related information (collectively "Health Information") for the purpose of payment, treatment, or health care operations to one or more of the following:

1. Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors, Medicare Medicaid, any other person or entity that may be responsible for paying or processing for payment any portion of my CCHCS bill or conducting utilization management/review and financial/medical audits;
2. To any person or entity affiliated with or representing CCHCS and any practitioner providing medical goods and services to patients for the purpose of payment, treatment and health care operations;
3. To any other hospital, nursing home, or other health care institution to which the patient is transferred;
4. Patient's primary, attending, consulting, referring, and/or family physician for follow up, physician information and/or continuity of care to include prospective or current home health company, to referring facility health care staff or to CCHCS.

In addition, I understand that the potential uses and disclosures of my Health Information are detailed in the Privacy Notice, a copy of which has been provided to me. I have read or will read the Privacy Notice and ask CCHCS if I have any questions about the information contained in the Privacy Notice. I agree to the uses/disclosure of my/my child's Health Information as described in the Privacy Notice. Moreover, I understand that the Privacy Notice may be amended by CCHCS from time to time and that I may obtain an amended Privacy Notice at any time by contacting CCHCS' registration/front office personnel or by obtaining an updated version at www.cookchildrens.org.

I give permission for the release of Health Information to be transmitted by U.S. Mail, facsimile or other electronic medium. I may revoke this Consent to Release Health Information in writing at any time, unless action has already been taken in reliance thereupon; in which case, I may revoke this Consent for future communications.

I give my permission to CCHCS and its agents, employees and representatives to use the contact information, including cell phone numbers, I have provided to contact me for payment (including but not limited to autodialed or prerecorded collection calls), treatment or any other health care purposes.

MEDICARE/TRICARE PATIENTS ONLY: I acknowledge receipt of the written material entitled "Important Message for Medicare/Tricare."

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AND RIGHTS: I hereby irrevocably assign, transfer and convey to CCHCS and any practitioner providing care and treatment to me/my child, any and all benefits and all interest and rights (including causes of action, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under an employee welfare benefit plan sponsored by my employer, all insurance policies, benefits, any third-party reimbursement, or prepaid health care plan for services rendered or products I receive from CCHCS. I agree to assist CCHCS in processing claims for such benefits including providing all necessary information to CCHCS or the payor in a timely manner. If my/my child's treatment was caused by events which result in legal action, I assign to CCHCS an interest in any claims I/my child may have arising from or in connection with the delivery services by CCHCS to me/my child. I understand that CCHCS's charges for the services rendered or products received are set out in CCHCS's Charge Master and I hereby promise to pay the full billed charges for all of the services rendered to me/my child less any applicable contractual discounts. In cases where no insurance policy is applicable or my insurance considers CCHCS out-of-network, I understand that I may be responsible for the full billed charges. I understand I am responsible for all health insurance copayments and deductibles and any other amounts properly payable by me as permitted by law or contract. Charity care may be available if CCHCS eligibility criteria are met.

DESIGNATION OF AUTHORIZED REPRESENTATIVE: I designate and appoint CCHCS (and its agents) as my authorized representative and authorize it to act on my behalf to (1) request and receive a copy of the summary plan description: (2) pursue a benefit claim; (3) appeal an adverse benefit determination; and/or (4) file a legal/equitable action to recover benefits from my employee welfare benefit plan, insurance policy, any third-party reimbursement or prepaid health care plan. I understand and agree that my authorized representative shall have full authority to act, and receive notices, on my behalf with respect to an initial determination of the claim for health benefits relating to treatment and health care services received by me/my child at CCHCS, any requests for documents relating to this claim and appeal of an adverse determination of the claim. This document shall remain in force until a written revocation by me is delivered to CCHCS.

MEDICAID PATIENTS ONLY: I understand that the amount owed to CCHCS for covered services will be satisfied by amounts paid by Medicaid for such services and that I will not be balance billed by CCHCS for Medicaid covered services. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my/my child's care. I understand that the Texas Health and Human Services Commission or its health insuring agent determines the medical necessity of the services or items that are received. I also understand that I am responsible for payment of the services or items I receive if these services or items are determined not to be reasonable and medically necessary for my/my child's care. If I am a Medicaid STAR patient, I acknowledge that some of these provisions may not apply.

I hereby certify and affirm that I have the legal authority to make the above assignment of benefits and designation of authorized representative and, if other than a parent of the child receiving treatment, will provide upon request appropriate legal documentation of such authority (e.g., legal guardianship, power of attorney, court order).

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND RECEIVED A COPY OF THE CCHCS NOTICE OF PRIVACY PRACTICES.

Patient's Name Printed: _____ Date of Birth: _____

_____ _____
Signature of Patient, if adult, or Patient's Parent/Legally Authorized Representative Relationship

_____
Witness

Time of Signing: Month _____ Day _____ Year _____ Hour _____ a.m./p.m.

CADMIT

Cook Children's
Health Care System

801 Seventh Avenue
Fort Worth, TX 76104
682-885-4000

Cook Children's

Notice of privacy practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who will follow this notice

This notice describes Cook Children's practices and those of:

- Any health care professional authorized to enter information into your medical record;
- Any volunteer we allow to help you while you are in our care; and
- All Cook Children's employees, staff and other personnel.

The following entities within Cook Children's Health Care System will follow these practices:

- W.I. Cook Foundation dba Cook Children's Health Foundation;
- Cook Children's Medical Center;
- Cook Children's Health Care System;
- Cook Children's Physician Network;
- Cook Children's Northeast Hospital;
- Cook Children's Pediatric Surgery Center; and
- Cook Children's Home Health

These entities, sites and locations follow the terms of this notice and may share protected health information with each other for treatment, payment or operational purposes described in this notice.

The term "you" in this notice represents either you or your child.

Your rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Cook Children's℠

Your rights – continued

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the contact information on the back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, DC 20201, calling 1-877-696-6775 or visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We also may share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information, unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Cook Children's℠

Our uses and disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

We may use third party business associates to perform these functions. To safeguard your protected health information, Cook Children's has agreements with these third parties that require them to appropriately protect your information.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease. • Helping with product recalls. • Reporting adverse reactions to medications. • Reporting suspected abuse, neglect or domestic violence. • Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions such as military, national security and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Contact information

Cook Children's
801 7th Ave.
Fort Worth, TX 76104

Website: cookchildrens.org

Privacy Officer
Phone: 682-885-1358
Email: privacyofficer@cookchildrens.org

Effective date: Dec. 1, 2014

CookChildren's℠

Authorization to Release/Obtain Protected Health Information ("PHI") for School Based Telemedicine Services

This form, if signed, will authorize Cook Children's Health Care System ("**CCHCS**") and/or its affiliate(s) ("**Cook Children's**") to use and release certain health information about the person named below. All items must be completed and the authorization signed and dated by an authorized person to be valid. I understand this authorization is voluntary, I may refuse to sign this authorization and I understand that Cook Children's may not withhold treatment because I refuse to sign this authorization.

1. **I authorize Cook Children's Physician Network and the School Nurse to release and/or obtain health information, as described below, from the medical and/or school records of:**

   Patient's Full Name: _____ Date of Birth: _____

2. **The information specified below may be released to and/or obtained by:**

   Cook Children's Physician Network, including its physicians and other health care providers ("CCPN")
   801 Seventh Avenue
   Fort Worth, Texas 76104
   (682) 885-6800

   Keller Independent School District, including its school nurses and other employees facilitating telemedicine services ("School Nurse")
   350 Keller Parkway
   Keller, Texas 76248
   (817) 744-1000

3. **The specific purpose(s) for this disclosure is:** To allow exchange of information between School Nurse and CCPN providers related to school based telemedicine services.

4. **Must select one:** □ I want **OR** □ I do not want the specified information to be released to include history, diagnosis and/or treatment for: HIV/AIDS/testing, Communicable diseases, Drugs/Alcohol, Mental Health disease.

5. **The information to be released and/or obtained includes:** Any relevant medical history available from the school, and a record of the telemedicine visit, including the results of the examination, any prescriptions provided, and any follow-up instructions. I further authorize any verbal communications between the school nurse and Cook Children's Physician Network, its physicians and other health care providers.

6. **I understand and acknowledge the following statements**: I may be asked to show proof that I have the authority to sign an authorization to review, receive or release to another party copies of the above named patient's medical record which I am requesting. In order to inspect or receive a copy of the medical record for myself, I must complete and sign this authorization form. If I request to do so, I may inspect the medical information to be released to another party after signing this form. Unless required or allowed by law, the medical information will not be released to another party, if, after inspecting the medical information, I revoke this authorization prior to the release of the medical information. After the above medical information is released, it may be re-released by the recipient and the information may no longer be protected by federal privacy laws or regulations. A facsimile or photocopy of this authorization is as valid as the original. I will be charged a fee for any copies of my medical records or my child's medical record I request for myself or for use by others. *Fees for copies are due and payable before copies are released.* I may revoke this authorization at any time by notifying Cook Children's in writing to ATTN: Cook Children's Health Care System, Health Information Management Department, of my intent to revoke this authorization, except that if I do notify Cook Children's in writing of my intent to revoke this authorization, such revocation will not have any effect on any actions by Cook Children's taken before the revocation. Unless otherwise revoked in writing, this authorization is valid until the following specific date (optional): Month_____ Day _____, Year _____ or if no date is indicated, until the patient's 18th birthday.

7. _____ _____ _____
   DATE Signature of Patient, Parent or Legally Authorized Representative Relationship to Patient

8. _____ _____
   Printed Name of Parent or Legally Authorized Representative ***Patient ID Number (Office use only)***

(NOTE: All items in this authorization must be completed to be valid and executable

CONSENT

CookChildren's.
Physician Network

Non-parental consent to medical/surgical care and treatment

I, _____ parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

Signature	Relationship to child(ren)	Date

Child(ren):

Name	Name
Name	Name

Authorized person(s):

Name	Relationship to child(ren)
Name	Relationship to child(ren)
Name	Relationship to child(ren)
Name	Relationship to child(ren)
Witness	Date

CookChildren's

Patient Medical History

Patient Name: _____ DOB: _____

Primary Care Physician:_____ Phone:_____

MEDICATION ALLERGIES

As far as you know, is your child allergic to any medications? YES ____ NO____

If YES, which medications, and what kind of reactions has he or she had?_____

_____

HEALTH HISTORY (please check all that apply):

- □ Problems in the newborn period
- □ An overnight hospital stay
- □ Surgery of any kind
- □ An accident or ingestion requiring a visit to the ER
- □ A broken bone
- □ A serious burn
- □ Frequent ear infections
- □ Frequent sinus infections
- □ Frequent sore throats
- □ Frequent headaches
- □ Sleep problems
- □ Problems with hearing
- □ Problems with vision
- □ Skin disease
- □ Respiratory allergies
- □ Asthma
- □ Pneumonia
- □ Other lung disease
- □ Heart disease
- □ Excessive vomiting or spitting up
- □ Digestive problems
- □ Liver disease
- □ Milk or food intolerance
- □ Frequent diarrhea
- □ Frequent constipation
- □ Frequent abdominal pain
- □ Urinary tract infection
- □ Other kidney disease
- □ Anemia
- □ Other blood disorders
- □ Seizure or convulsion
- □ Head injury/concussion
- □ Other neurological disease
- □ Psychiatric or emotional problems
- □ Behavioral problems
- □ Cancer or tumor
- □ Metabolic disease
- □ Bone or joint disease
- □ Immune disorder
- □ Genetic disease
- □ Chicken pox date:
- □ Other serious illness

Please tell us about any health conditions marked above or any other concern's you may have about your child's health:

_____

_____

_____

Parent Signature: _____ Date: _____

revised 8/15/2016