Beaufort Jasper Hampton Comprehensive Health Services, Inc.

Glasscho Hope Wellness School Based Health Centers

Form Name	Purpose
Registration*	**Complete entire form** to provide information that is necessary to enroll your child in School Based Health Services and to communicate with you.
Student Health Information*	**Complete form and sign** to provide the Doctor/Nurse Practitioner/Dentist/Hygienist with accurate and updated health and dental history in order for our staff to provide your child with the proper treatment.
Consent for Treatment*	**Signing** this form allows your child to receive School Based Health Services in the school.

*All information received is protected and remains confidential.

Frequently Asked Questions	Answers
What is the benefit of School Based Health Center?	**Convenient and affordable health services** to prevent your child from missing school for many illnesses if treated sooner. You can avoid taking time off from work to take your child to the doctor.
What School Based Health Services are offered?	**Medical, TeleHealth, Dental, Nutrition, and Behavioral Health** services areoffered by highly qualified Beaufort Jasper Hampton Comprehensive Health Services, Inc. providers.
What is TeleHealth?	The provider examines the student through high definition visual and audio equipment, if the medical provider is not available at the school on the day your child is sick.
Does these services take the place of my child's doctor or dentist?	**No.** School Based Health Center Medical and Dental Services are a supplement to your child's current doctor or dentist.
What is the difference between the school nurse and the School Based Health Center?	Our School Based Health Center providers can **write prescriptions and provide treatment** for health/dental conditions, such as, Flu, Strep throat, ear infection, Asthma, tooth infection, etc.
How will I be notified?	The **Parent/Guardian will be contacted by phone and/or sent home a Parent Communication Letter** with your child each time your child is seen by our staff.
If I have Medicaid do I have to pay?	**No.** If your child has Medicaid, Medical and Dental Services are at no charge.
What if my child does not have insurance?	If your child has no insurance, you can pay the annual **$30 for Medical Services** for the entire school year, and annual **$50 for Dental services** for the entire school year. **You have the option to choose either Medical or Dental Services or both.**
What if my child has insurance other than Medicaid?	You will be responsible for the co-pay/deductible and will be billed as you normally would in a health clinic. Most insurances accepted.

Contact your child's School Nurse or Allison Jackson, FNP, School Based Health Center Director at ajackson@bjhchs.org or 843-812-9635 for additional questions or concerns.

RETURN COMPLETED ENROLLMENT PACKET TO SCHOOL NURSE

BEAUFORT- JASPER – HAMPTON COMPREHENSIVE HEALTH SERVICES, INC.

NAME_____ DOB_____
GRADE_____ TEACHER_____
SCHOOL_____
CHART #:_____

SCHOOL BASED HEALTH REGISTRATION FORM

Today's Date:_____ ReviewDate:_____
FOR REGISTRATION PERSONNEL ONLY – **DO NOT WRITE IN THIS SPACE**

Which of our centers have you visited: (Please check the location)
⎦ Port Royal Center ☐ Hampton Center ☐ Chelsea Center ☐ Hardeeville Center ☐ School Based Health Center _____
⎦ Sheldon Center ☐ Ridgeland Center ☐ St. Helena Center ☐ Estill Center ☐ Port Royal Same Day Health Clinic

Patient/Student Information

Last Name	First Name	Middle Initial	Sex at Birth ⎦ Male ⎦ Female	Date of Birth	Social Security Number

Street Address	City	State	Zip	County

Race
⎦ Black ☐ White ☐ Hispanic/Latino ☐ Asian ☐ American Indian
⎦ Pacific Islander ☐ Native Hawaiian ☐ Undeclared

Ethnicity
☐Not Hispanic ☐ Hispanic/latino
☐Another Hispanic/latino ☐Other_____

Parent/Guardian Information (Enter name of person financially responsible for account)

Last Name	First Name	Middle Initial	Social Security Number

Street Address	City	State	Zip	County
Mailing Address/PO Box	**City**	**State**	**Zip**	**County**

Home Phone ( )	Cell Phone ( )	Work Phone ( )	Date of Birth	Sex at Birth ☐Male ☐Female	Marital Status ⎦ Single ☐ Married ☐Separated ☐ Divorced

Email address	Pharmacy name & location	Annual Income	Family Size

Emergency Contact Name & Relationship to student	Phone Number

Do you work on a Farm?
⎦ No ☐ Seasonal ☐ Migrant ☐ Employed Farm-worker
⎦ Unemployed Farm-worker ☐ Other

Housing Status
⎦ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up
⎦ Street ☐Other

Insurance Company

Primary Insurance	ID #	Group #	Insurance Company Address
Name of Insured	**Insured's Employer**	**Relationship to Responsible Party** ⎦ Self ☐ Spouse ☐ Child ☐Other	
Secondary Insurance	**ID #**	**Group #**	**Insurance Company Address**
Name of Insured	**Insured's Employer**	**Relationship to Responsible Party** ⎦ Self ☐ Spouse ☐ Child ☐Other	

School Based Health Center Service Fees for Uninsured

Medical/Nutrition/Behavioral Health services
$30 Annual Fee: only if your child is **not** covered by MEDICAID or other insurance. ☐ **Fee enclosed** (uninsured)
If paying by check please make payable to BJHCHS, Inc.

Dental services
$50 Annual Fee: only if your child is **not** covered by MEDICAID or other insurance. ☐ **Fee enclosed** (uninsured)
If paying by check please make payable to BJHCHS, Inc.

Acknowledgment: I acknowledge receipt of the: Notice of Privacy Practice ☐ Yes Patient Rights and Responsibilities ☐ Yes

Signature of person providing information:_____ Date:_____

The attached CONSENT FOR TREATMENT & Health Information forms must be completed before your child will be seen. Thank you.

Student Health Information

Chart #_____

Student's Name:_____Birthdate:___/___/___Grade: _____

MEDICAL HISTORY

Does this child have a regular doctor? YES NO

If YES, who? _____

If NO, what is your usual source of medical care? _____

_____

Date of this child's last Physical/medical check-up? _____

_____ Where?_____

Are child's immunizations (shots) up to date? YES NO

Is a copy of the shots record on file at the school? YES NO

Has this child been seen in the emergency room in the past year? YES NO If YES, why?_____

Has this child ever been in the hospital? YES NO

When?_____Why? _____

Has this child ever had surgery? YES NO When?_____

What kind? _____

Does this child have Behavioral/Developmental/School problems? ***(learning delays, ADHD, Down's Syndrome, Autism, etc.)***

YES NO If YES, what? _____

_____

Please list any of this child's allergies (medicine, food, latex, pollen, insects, dust, etc.): _____

_____

Does your child take any daily medications? YES NO

If YES, what medication and how often taken?

_____

_____

Do you have well water? YES NO

***FAMILY HEALTH HISTORY*:**

If any of this child's relatives suffer from any of the following illnesses, please fill in the relationship to the child, and note if they are deceased. (Example: Grandmother, Mother, Aunt, Sister, etc.)

Diabetes_____

Cancer_____

Heart Disease _____

Stroke_____

Tuberculosis_____

Seizures_____

Asthma_____

Allergies_____

DENTAL HISTORY

Does this child have a regular dentist? YES NO

If YES, who_____

Date of this child's last dental check-up? _____

Has this child ever had difficulties associated with dental treatment? YES NO If YES, what kind of difficulties?

_____

Does your child have to take medication before being checked by a dentist? YES NO If YES, what kind of medication_____

Has *this child* ever had any of the following conditions:
(please circle correct answer)

Rheumatic Fever of Rheumatic Heart Disease	Yes No
Heart Valve Problems/Surgery	Yes No
Heart Murmurs	Yes No
Heart Problems/Congestive Heart Failure	Yes No
Stroke	Yes No
Jaundice	Yes No
Kidney Disease	Yes No
Prolonged Bleeding	Yes No
ADD/ADHD	Yes No
Autism	Yes No
Down's Syndrome	Yes No
Tuberculosis	Yes No
Diabetes	Yes No
Anemia	Yes No
Seizures	Yes No
Hepatitis	Yes No
Eczema	Yes No
Asthma	Yes No
Medication/Inhaler	Yes No
Chicken Pox	Yes No
Ear Infections (frequent)	Yes No

Signature of person completing this form **Date** / /

Student Name:_____**DOB:**_____**School:** _____

CONSENT FOR TREATMENT for School Based Health Services

I,_____, parent or guardian of_____, hereby authorize Beaufort Jasper Hampton Comprehensive Health Services, Inc. School Based Health Center (SBHC) to provide medical, telemedicine, dental, nutrition, social worker/behavioral health services including, but not limited to, a medical examination, health education, behavioral health screening. Treatments and medications may be ordered as advised by the attending professional.

I understand that Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS) Provider may request and use prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes only.

I understand that I am giving consent to bill my insurance carrier for services provided in the SBHC and to release information about my child's medical condition as may be ordained necessary or advisable by the attending professional. I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles and co-pays. If child is uninsured, I understand that I will be liable to pay the annual school based fees applicable to the services provided. I understand that this consent is voluntary and is valid only for services provided at the School Based Health Center. I understand this consent form is valid, until I revoke it in writing.

I agree and give my consent for my child to receive the following services:
Parent or guardian signature is required for EACH service you wish your child to receive.

Medical/Nutrition Services
Signature of parent/guardian: _____ **Date**: _____

Behavioral Health Services ****Please note that prior to counseling sessions are initiated the student will first be evaluated by the Pediatrician or Family Nurse Practitioner. In order for the student to receive Behavioral Health Counseling Services consent MUST be given for Medical services (sign line above and below)***
Behavioral Health counseling services including behavioral health screening, assessment, and/or counseling. I understand that no mental health medications will be prescribed without my explicit permission. An appointment with the psychiatrist will be made available to discuss whether my child would benefit from the use of psychiatric medications.

Signature of parent/guardian:_____ **Date**: _____

Dental Services AND Dental Anesthesia Consent
Dental treatment provided to your child while in school may require use of local anesthetics. This may result in a traumatic ulceration of the lip when children chew their numb lip after a dental appointment. If this should occur we recommend over the counter Anbesol, Orajel or Orabase with benzocaine as topical anesthetics. Healing usually occurs within two (2) weeks. Severe trauma usually requires antibiotics.
Signature of parent/guardian:_____ **Date**: _____

Mission Statement

The Mission of Beaufort-Jasper-Hampton Comprehensive Health Services, Inc., is to provide, quality, accessible, affordable and comprehensive health care to the South Carolina Lowcountry Community

Patient's Rights

- ✓ **Respect and Dignity** – The patient has the right to considerate, respectful care at all times under all circumstance with recognition of their personal dignity, cultural, spiritual, social and personal values, belief and preferences recognized.
- ✓ **Privacy and Confidential** – The patient has the right, within the law, to personal and information privacy.
- ✓ **Involvement in Care, Treatment & Services** - The patient and/or their legal representative has the right to be involved in all decisions concerning their care, treatment and services.
- ✓ **Personal Safety & Security** - The personal has the right to expect reasonable safety & security insofar as the center practices and environment is concerned.
- ✓ **Identity** – The patient has the right to know the identity and professional status of individuals providing service and to know which physician or other practitioner is primarily responsible for their care.
- ✓ **Information** – The patient has the right to obtain, from the practitioner responsible for coordinating their care, complete and current information concerning their diagnosis (if known), treatment any known prognosis, care, and expected or unanticipated outcomes.
- ✓ **Assistance** – The patient has the right to ask questions and discuss problems that arise during an office visit. BJHCHS provides an individual to handle patient complaints.
- ✓ **Consents** – The patient has the right to reasonable informed participation in decisions involving their care, treatment, services, medications, interventions and procedures.

Patient's Rights cont...

- ✓ **Recording/Filming** – The patient has the right to be informed and to consent to filming or recording. The purpose and circumstances of the recording or filming will be fully explained. The patient has the right to rescind the consent.
- ✓ **Consultation** – The patient at their own request and expense has the right to consult with specialists.
- ✓ **Refusal of Treatment** – The patient may refuse care, treatment, and services to the extent permitted by law.
- ✓ **Patient Charges** – Regardless of the source of payment for care the patient has the right to request and receive an itemized and detailed explanation of the total bill for services rendered.
- ✓ **Patients Rules and Regulations** – The patient should be informed of the rules and regulations applicable to conduct as a patient.
- ✓ **Pain Management** – The patient has the right to effective pain management.
- ✓ **Communication** – The patient has the right to effective communication.
- ✓ **Abuse** – The patient has the right to be free from physical, mental, sexual, and verbal abuse or neglect and/or being taken advantage of in any form.
- ✓ **Research** – The patient has the right to be protected during research and their rights respected.
- ✓ **Advanced Directives** – The patient has the right to have their wishes regarding end of life decisions respected and information and assistance provider concerning advance directives.

Vision

We strive to provide the most comprehensive healthcare delivery system that will meet the needs of the Lowcountry Community

Patient's Responsibilities

Beaufort-Jasper-Hampton Comprehensive Health Services, Inc. as a provider of health services has a right to expect reasonable, responsible behavior on the part of patients.

Characteristics of such behavior are:

- ✓ **Provision of Information** - A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications and other matters relating to their health. Any changes in condition must be communicated to the practitioner.
- ✓ **Compliance with Instructions** – A patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for their care.
- ✓ **Refusal of Treatment** – The patient is responsible for their actions if treatment or plan of care is refused or if the practitioner's instructions are not followed. The patient is responsible for any outcome should the plan of care not be followed.
- ✓ **Patient Charges** – The patient is responsible for following the center rules and regulations regarding payment for services.
- ✓ **Respect and Consideration** – The patient is responsible for being considerate of the rights of other patients and center personnel and for assisting in the control of noise, smoking and eating in the center.
- ✓ **Questions** – The patient is responsible for asking question when they do not fully understand their care, treatment or services.
- ✓ **Rules and Regulations** – The patient is responsible for following the agency's rules and regulations.

Requesting Restrictions

You have the right to request a restriction in our use or disclosure of your medical information for treatment, payment or health care operations. You have the right to restrict certain information from being sent to your health plan where you have paid in full out of pocket. Additionally, you have the right to request that we limit our disclosure of your medical information to individuals involved in your care or the payment for your care, such as family members or friends.

We are not required to agree to your request unless you have paid in full the cost for services or items; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your medical information, you must make your request in writing to:

BJHCHS, Inc.
Attn: Julia Williams, Privacy Officer
P.O. Box 357
Ridgeland, SC 29936
843-987-7400

Your request must describe in a clear and concise fashion:

- The information you wish restricted
- Whether you are requesting to limit our practice's use, disclosure or both
- To whom you want the limits to apply

Confidential Communications

You have the right to request that our organization communicate with you about your health and related issues in a particular manner, or at a certain location. For instance, you may ask that we contact you by mail, rather than by telephone, or at home rather than work. In order to request a type of confidential communication, you must make a written request to the previously stated address. You must specify the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate reasonable requests. You do not need to give a reason for your request.

Inspection and Copies

You have the right to inspect and obtain a copy of the medical information, either paper or electronic, that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the previously stated address in order to inspect and/or obtain a copy of your medical information. Our Agency may charge a fee for the costs of copying, mailing, labor and supplies associated with your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted not by the person that denied your request, but by another licensed health care professional chosen by us.

Amendment

You may ask us to amend your medical information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept by or for our Agency. To request an amendment, your request must be made in writing and submitted to the previously stated address. Our organization will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is:

- Accurate and complete
- Not part of the medical information kept by or for the Agency
- Not part of the medical information which you would not be permitted to inspect or copy
- Not created by our organization, unless the individual or entity that created the information is available to amend the information

Accounting of Disclosures

You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures our organization has made of your medical information. In order to obtain an accounting of disclosures, you must submit your request in writing to the previous stated address.

All requests for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12month period is free of charge, but our organization may charge you for additional lists within the same 12-month period. Our organization will notify you of the costs involved with additional requests and you may withdraw your request before you incur any costs.

Breach of Information

You will be notified concerning any breach of your information unless through risk assessment it is determined that there is a low probability that your information was compromised.

Right to a Paper Copy of this Notice

You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. In order to obtain a paper copy of this notice, contact the previous stated address.

Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, you must submit your request in writing to the previous stated address.

- You will not be penalized for filing a complaint.
- All complaints will be investigated.
- No retaliation will occur

Right to Provide an Authorization for Other Uses and Disclosures

Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your information. Of course, we are unable to take back any disclosures that we have already made with your permission. Please note that we are required to retain records of your care.

Our responsibilities to you:

- To abide by the terms of this notice to protect your medical information
- To maintain the privacy of your medical information
- To provide you with this notice of our legal duties and privacy practices
- To notify you if we are unable to agree to a requested restriction

We reserve the right to change the terms of this notice. New or revised provisions and practices will be provided to you by mail or at your next scheduled appointment.

Effective date of this notice: April 3, 2003
Revised date: September 17, 2013

CENTERS • BEAUFORT COUNTY • JASPER COUNTY • HAMPTON COUNTY

BEAUFORT JASPER HAMPTON

COMPREHENSIVE HEALTH SERVICES
BJH • Beaufort • Jasper • Hampton SOUTH CAROLINA

COMPREHENSIVE HEALTH SERVICE, INC

Privacy Notice

Chelsea Medical Center
721 Okatie Highway 170
Ridgeland, SC 29936
Telephone: (843) 987-7400
Fax: (843) 987-7484

Port Royal Medical Center
1320 South Ribaut Road
Beaufort, SC 29935
Telephone: (843) 986-0900
Fax: (843) 986-0566

St. Helena Island
6315 Jonathan Francis Sr. Rd
St. Helena, SC 29920
Telephone: (843) 838-2086
Fax: (843) 838-3906

Estill Medical Center
454 2nd Street
Estill, SC 29918
Telephone: (803) 625-2548
Fax: (803) 625-2801

Hampton Medical Center
200 Elm Street
Hampton, SC 29924
Telephone: (803) 943-2233
Fax: (803) 943-0268

Sheldon Medical Center
211 Paige Point Road
Sheldon, SC 29942
Telephone: (843) 846-8026
Fax: (843) 846-8312

Hardeeville Medical Center
8 Stiney Road
Hardeeville, SC 29927
Telephone: (843) 784-2181
Fax: (843) 784-6112

Ridgeland Medical Center
1520 Grays Highway
Ridgeland, SC 29936
Telephone: (843) 726-3979
Fax: (843) 726-4287

PRIVACY NOTICE

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

Beaufort Jasper Hampton Comprehensive Health Services, Inc. (BJHCHS, Inc.) uses your health information for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the property of BJHCHS, Inc.'s. We are dedicated to maintaining your privacy and your medical record information.

How We May or May Not Use or Disclose Your Health Information For Treatment: BJHCHS, Inc. may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse or other person providing health services to you, will discuss information in your chart that is related to your treatment. These communications are for health care providers to coordinate and manage your health care. The provider may speak with another doctor, specialist, pharmacist, hospital or health care organization to help manage and coordinate your care. Healthcare providers will also record actions taken by them in the course of your care and note your progress.

For Payment: We may use and disclose your health information to others for purposes of receiving payment for providing your care. For example, a bill may be sent to you or a third-party payer, such as an insurance company. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. We may call your insurance company to verify eligibility, billing, claims, pre-certification and other activities. You may request that we not disclose certain information to your health plan where **you** have paid in full for the health service or item.

For Healthcare Operations: We may use and disclose healthcare information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to:

- Review the competency of our staff
- Assess the quality of care and outcomes in your cases and similar cases
- Conduct business planning and development to improve our facilities and services
- Determine how to continually improve the quality and effectiveness of the health care we provide
- Resolve complaints or concerns you may have regarding your care

For Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. We may write or call you for these purposes.

Involvement in Care: We may disclose information about you to a family member, close personal friend or other person you identify if specifically needed, or that person's involvement with your care or payment related to your health care.

For Marketing: We will not use or disclose information for marketing purposes or sell your information. We may write to you concerning health related products or services that might be of interest to you.

For Fundraising: If we contact you concerning fundraising you have the right to opt out of further communications.

As Required by Law: We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

Lawsuits and Similar Proceedings

We may use and disclose your medical information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your medical information in response to a discovery request, subpoena, or other lawful process.

Abuse, Neglect and Domestic Violence:

We may disclose your medical information to a government authority regarding possible abuse, neglect or domestic violence if we believe you are a victim of abuse, neglect or domestic violence. If we make such a disclosure, we will inform you of it, unless we think that informing you places you at risk of serious harm or, if we were to inform your personal representative, is otherwise not in your best interest.

Law Enforcement

We may disclose your medical information to assist law enforcement officials in their duties in response to a warrant, summons, court order, subpoena, or similar legal process such as:

Identifying or locating a suspect, material witness, fugitive or missing person

Regarding criminal conduct at our offices

Concerning a death we believe might have resulted from criminal conduct

In an emergency if you are a victim of a crime

Regarding a crime victim

Any criminal investigation where you consent to release of medical information

Public Health:

Your public health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury or disability or for other health oversights activities pursuant to law.

We may disclose your medical information for public health activities pursuant to law, including generally:

- To prevent or control disease, injury or disability
- To report child abuse or neglect
- To notify a person regarding potential risk for spreading communicable disease
- To notify a person regarding potential risk for spreading or contracting a disease or condition
- To report reactions to drugs or problems with products or devices
- To notify individuals that a product or device they may be using has been recalled
- To notify appropriate Agency (ies) and Authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information;
- To notify your employer under limited circumstances, related primarily to workplace injury or illness or medical surveillance

Psychotherapy: We will not disclose most information about any psychotherapy notes.

Decedents

Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties. Your information will not be disclosed for 50 years following your death.

Organ/Tissue Donation

Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes. Where you have properly provided by will or otherwise designated authorization form.

Research

We may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and you have signed an authorization.

Emergency

Your health information may be released to other healthcare Providers in the event you need emergency care.

Health and Safety

Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Student Disclosures

We may disclose proof children's immunizations to the schools. Adults and emancipated minors will need to agree either orally or in written form for theirs to be released.

Serious Threats to Health or Safety

We may use and disclose your medical information based on a reasonable belief that the information was necessary to prevent or lessen a serious and imminent threat to health or safety of an individual or of the public. The information would be released to a person or persons reasonably able to prevent or lessen the threat, in emergency circumstances.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the Armed Services that may require use or disclosure of your health information, as prescribed by law.

Specialized Government Functions

We may disclose your medical information if you are a member of U.S. military (including victims) if required by the appropriate military command pursuant to legal process or court order.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation

Workers' Compensation

We may release your medical information to comply with Worker's Compensation and similar programs that provide benefits for work-related illnesses or injuries pursuant to legal process.