SCHOOL-BASED HEALTH PROGRAM CONSENT FOR TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Chillicothe City School District ("District") and Adena Health ("AH") are partnering to offer a school-based health program to District students (the "Program"). The goal of the Program is to help improve the health and well-being of students so that they can be successful in school. The purpose of the Program is to provide quality healthcare in a friendly and familiar school setting at a time that is convenient to the student and family. Although we are happy to fill the need of a Primary Care Provider, you are not required to transfer your care to AH prior to or after being seen. The District will still provide school nursing and emergency services as always whether you consent to participate in this program or not.

Patient / Student Information:

Patient/Student, First and Last Name _____ Parent/Legal Guardian, First and Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth (Month-Day-Year) _____ School & Grade Level _____

Primary Care Provider _____ Primary Care Provider's Phone Number _____

Primary Care Provider's Street Address _____ City _____ State _____ Zip Code _____

Consent for Medical Care/Treatment:

I wish to have **ALL** applicable services / treatments available for the above referenced patient/student.

☐ **YES** ☐ **YES TO SOME** (Make selections of services/treatments you do consent to have available below)

	Care and treatment for any injury/illness		Pregnancy Testing
	Mental/Behavioral Health Treatment		Birth Control
	Physical Examinations / well-child (i.e. sports, work, school) **Note:** Well-child includes vision and hearing screening, urine and blood tests, and an external genital exam when appropriate		

☐ **DECLINE** to have any applicable services / treatments available for the above referenced patient/student.

*** IF Checked YES/ YES TO SOME please complete:**

Insurance Name_____ Subscriber Number_____

Group Number_____ Group Name_____

Insured Name_____ Relationship to Patient_____

Consent for Vaccinations:

I wish to have **ALL** vaccines available for the above referenced patient/student.

☐ **YES** ☐ **YES TO SOME** (Make selections of vaccines you do consent to have available below)

Required Vaccines* for School Attendance in Ohio		Recommended are noted below	
	*DTaP / Tdap / Td (Required)		Influenza (flu) – (Recommended)
	*Meningococcal A (Required)		Human Papilloma Virus (HPV) – (Recommended)
	*Measles Mumps Rubella (MMR) –(Required)		Meningococcal B (Recommended)
	*Varicella (Required)		*Pneumococcal (Required)
	*Polio (Required)		*Hib (Required)
	*Hepatitis A & B (Required)	*Age appropriate, following the American Academy of Pediatrics vaccination schedule	

☐ **DECLINE** to have any applicable services / treatments available for the above referenced patient/student.

SIGNATURE For Consent of Treatment:

Parent/Legal Guardian *Printed* Name (If student is less than 18)	**Parent/Legal Guardian *Signature*** **Date/Time**
Student *Printed* Name (if student is 18+)	**Student *Signature*** **Date/Time**

Authorization to Release Medical Information

There are a few instances in which we can provide treatment and/or testing to your minor child without parent/legal guardians consent **under Ohio law.** Provided below are those instances:

- STD testing and treatment, *HIV/AIDS is limited to testing only
- Drug or alcohol abuse and treatment
- Mental health services if 14 years or older and only for a limited period of time, *not including medication.
- Sexual assault examination

Although minors may be able to consent to the above treatment, this doesn't mean it will be kept confidential. Medical Records, with limited exceptions, may still be obtained by the parent/guardian and the child's insurance on record will still be billed.

By signing this consent, I am authorizing AH to provide the services to my minor child outlined in this form and to bill me/my insurance for any services rendered to my child at AH. I understand that this consent for treatment will remain valid for one year from the signed date below, unless I revoke or makes changes sooner. I understand that I may make changes at any time to this consent or revoke it entirely by making a written request to AH. I understand that even if I revoke my consent, as a parent of a minor child, my minor child may still consent to the treatment for which they are allowed to by law as described above. I have reviewed this consent and understand the services available. It is my responsibility to tell AH about changes in insurance coverage or changes to my child's health condition(s), immunization records, or medications. I further understand that, by signing below, I am authorizing AH and District to share my/my child's medical information with each other for the purposes of treatment and care coordination. Additionally, I authorize AH to request medical records/information from any health care provider or facility where my child has been seen and to send results of any treatment to my child's regular doctor/clinic. Furthermore, by signing below I am attesting that I am the parent/legal guardian of the above-named child and understand that a new consent form must be signed by a legal guardian if this would change. Finally, I understand that if I am not this child's birth parent that I must provide documentation or an explanation of my ability to sign this consent on behalf of the minor child and have attached such documentation to this consent.

I authorize AH and District to share/release/exchange my/my child's health information with each other, including, but not limited to, information regarding services provided to me/my child at school and/or in the Program, for treatment and care coordination purposes.

☐ **YES** ☐ **NO** (If checking "NO", please do NOT sign below)

SIGNATURE for Release of Medical Authorization:

Parent/Legal Guardian *Printed* Name (If student is less than 18)	**Parent/Legal Guardian *Signature***	**Date/Time**
Student *Printed* Name (if student is 18+)	**Student *Signature***	**Date/Time**

Consent to use AI Scribe

Adena Health is committed to providing the best possible care for you, and as part of this commitment, we continually seek ways to enhance our services and your experience.

We would like to inform you about a new technology that we are using called **AI Scribe**!

Purpose of AI Scribe:
AI Scribe is a dictation technology that converts spoken words into text format to efficiently and accurately document medical information. This technology may be used to transcribe medical notes, reports, and other documents related to a patient's care.

How AI Scribe Works:
During your care at Adena Health, any verbal information provided by you or your healthcare provider may be recorded using AI Scribe. The AI device does not interact directly with you but will record any spoken words during your care in text, which will be incorporated into your medical record. AI Scribe will not be used to make any decisions about your care and in no way replace your healthcare provider's independent decision-making related to your care. Your healthcare provider will review all information in your medical record, including any notes generated by AI Scribe, before making any care decisions. The use of AI Scribe allows your healthcare provider to focus more on you during your care and less on computer documentation, which in turn can give you more time with your provider.

Privacy Measures:
Adena Health employs strict security measures to ensure the confidentiality and integrity of information processed through AI Scribe and adheres to all guidelines of the Health Insurance Portability and Accountability Act (HIPAA). These measures include encryption, access controls, and regular security audits to protect against unauthorized access and data breaches.

Patient Rights:

1. Access to Information: I have the right to request access to my medical records and any transcripts generated through AI Scribe.
2. Amendment of Information: I have the right to request corrections or amendments if inaccuracies are identified in my medical records.
3. Withdrawal of Consent: I have the right to withdraw my consent for the use of AI Scribe at any time by submitting a **Request to Withdraw Consent for Use of AI Scribe** form.

Acknowledgment:
By signing below, I acknowledge that I have read and understood this consent form and the use of AI Scribe. I voluntarily agree to the use of AI Scribe to document my medical information with all of my Adena Healthcare providers. Further, I understand that this consent will be valid for all my healthcare providers at Adena Health until I revoke such consent in writing.

Patient Name: _____ DOB: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if under 18): _____ **Date:** _____