GATEWAY SCHOOL-BASED HEALTH CENTER CONSENT TO TREAT AND AUTHORIZATION TO DISCLOSE INFORMATION FORM

Last Name _____ First_____ Middle_____

Street _____ City_____ State _____ Zip _____

Home Phone #_____ Date of Birth_____ Sex ____M____F Grade _____ Staff _____Community _____

Do you have any allergies? (Please list)_____

Mother's Name_____ Daytime Phone #_____

Father's Name_____ Daytime Phone #_____

In order to continue our services the state & federal funding agencies request the following information:
Number of family members in household? _____ Annual income to the nearest thousands $_____

INSURANCE INFORMATION : **Check if you have no insurance**: _____

Insurance Company
_____

Company Address
_____

Policy No. Group No.
_____

Policy Holder
_____

Name of Employer
_____

Mass Health #
_____

01_____ #

02_____ #

03_____ #

04_____ #

FAMILY INFORMATION

Primary Care Physician Address Phone No.
_____

Family Drug Store Address Phone No.
_____

Please list all household members:

Name: D.O.B Sex Relationship

1._____

2._____

3._____

4._____

Would you or your child be willing to be seen by a supervised Nurse Practitioner/Mental Health Intern ? _____Y_____N

Name of friend or relative to notify in case of Emergency:

Name_____ Phone #_____

I consent and give permission for (me/my child or ward) to be treated by, and to receive medical or mental health services from, the Gateway School-Based Health Center ("GSBHC") at the Gateway Regional Middle and High School (the "School"). I understand that such medical or mental health services may be provided by or at the direction of a physician, nurse practitioner, or mental health professional.

If the patient is a GSBHC student, I consent to and authorize the disclosure of patient information and records ("Patient Information") by GSBHC to the School and its agents, and for the exchange of Patient Information between GSBHC and the School and its agents, which such Patient Information may include but is not limited to medical or mental health information or records that may relate to: HIV or AIDS, venereal disease, psychiatric or mental health, alcohol or drug abuse, or communications with psychologists, psychotherapists, social workers, allied mental health providers, domestic violence counselors, or sexual assault counselors. I also consent to and authorize the disclosure of Patient Information by GSBHC to the patient's primary care provider and other providers for treatment purposes and to insurers and other third party payors for billing and payment purposes. I understand that my insurer may be billed for any services provided by GSBHC to the patient and that my insurer may receive Patient Information as needed for billing and payment purposes. I understand that GSBHC also will disclose Patient Information as may be required by relevant law. This consent and authorization shall remain in effect as long as the patient is a student in the School, unless I rescind this consent and authorization in writing.

I understand that, under Massachusetts law, there are certain circumstances where minors have the right to consent, on their own, to confidential diagnosis and treatment. These circumstances can include, for example, treatment for sexually transmitted diseases, pregnancy, substance abuse, mental health, and medical emergencies, or where the minor is married, a parent, or self supporting. For such treatment authorized by minors only, the parent/guardian is not responsible for payment. In all these cases, the minor is encouraged to share information with the parent/guardian when appropriate. Please call GSBHC with any questions.

Signature of Patient (Adult or Emancipated Minor)_____

[OR] Signature of Parent/Guardian _____ Date: _____