ORAL HEALTH PARTNERSHIP
PERMISSION CERTIFICATE AND RELEASE

Instructions: Complete each section below and return this form to school. A copy of this form must be on file with Pulaski Community School District prior to service delivery in a District or school or clinic.

Student Name:	D.O.B.:

Permission to Treat

The above-named student has my permission to receive dental services from the Oral Health Partnership while enrolled as a student in the Pulaski Community School District during the academic day. Oral Health Partnership staff will work with school staff to determine the least disruptive time to deliver services.

Parent/Guardian Signature: _____ Date: _____

Voluntary Authorization to Obtain and Disclose Information

I, the undersigned, hereby authorize the Pulaski Community School District to disclose to the Oral Health Partnership by any means (verbal, written or electronic) the following records regarding the above-named student: student schedule, name of teacher, and the student's location during the school day for purposes of locating student to provide dental services. I understand that the information is requested for the purpose of delivery of dental services. I understand that I have a right to a copy of the records that are disclosed and a right to a copy of this authorization. I understand that my authorization is voluntary.

Withdrawal of Authorization: I understand that I have a right to revoke this authorization, except to the extent that disclosure has already been made in reliance on this authorization. I understand that my revocation is effective only if it is in writing and it is submitted to the individual/agency that is releasing information.

This permission is valid for the duration that the above-named student is enrolled in the Pulaski Community School District. A copy of this form is as effective as the original. I certify that I am the parent or legal guardian of the above-named student, or that I am the student and of majority age and have authority to sign the release.

Signature (Parent/Guardian)	Date:
Signature (Student- if applicable)	Date:
Print Name (Parent/Guardian)	Relationship to Student

Cc: Parent/Legal Guardian
Student Cumulative File

Notice of Privacy Rights

I understand that there are certain rights to privacy regarding the protected health information of my child or others for whom I am the legally appointed guardian. These rights are given under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize you to use and disclose protected health information for my child or minor for which I am the legally appointed guardian to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in health/medical treatment);
- Obtaining payment from third party payers; (e.g. medical assistance);
- The day to day healthcare operations of OHP's practice (including, but not limited to, exchanging information with my child's or minor's school and district in which he or she is enrolled as may be necessary to facilitate the provision of treatment); and -
- Such other functions and purposes permitted by HIPAA.

I understand that, unless I inform you to the contrary in writing, this Authorization covers all past, present, and future time periods and, further, that this Authorization permits the use and disclosure of the complete health record for my child or minor for which I am the legally appointed guardian.

I understand that I may revoke this Authorization, in writing, at any time. However, any use or disclosure that occurs prior to the date I revoke this authorization is not affected.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.