ORAL HEALTH PARTNERSHIP
PERMISSION, CERTIFICATION AND RELEASE

INSTRUCTIONS: Complete each section below and return this form to your child's school. A copy of this form must be on file with Green Bay Area Public School District prior to service delivery in a District 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 Green Bay Area Public 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 Green Bay Area Public School District to disclose to the Oral Health Partnership by any means (*e.g.,* verbal, written or electronic) the following records regarding the above-named student: student schedule, name of teacher, and 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 (a fee for education record copies may be imposed). 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 Green Bay Area Public 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 this release.

Signature (Parent/Legal Guardian) Date

Signature (Student – if applicable) Date

Print Name (Parent/Guardian)

Relationship to Student (parent, legal guardian, personal representative or adult student)

cc: Parent/Legal Guardian
Student Cumulative File (Consent Folder)

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information and/or the protected health information of my child or others for whom I am the legally appointed guardian. These rights are given to me and/or my child or minor under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my 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 my complete health record or that of 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.