SCHOOL-BASED TELEMEDICINE CENTERS
Participation and Data Sharing

Dear Parent/Guardian:

The Howard County Public School System (HCPSS) and the Howard County Health Department (HCHD) have partnered to implement school-based wellness telemedicine centers. Telemedicine centers use a secure, two-way link to transmit videos and images between your school's private health suite and the telemedicine provider. The current telemedicine providers are the Howard County General Hospital, Columbia Medical Practice, and Klebanow M.D. and Associates.

In order for your student/child to receive telemedicine services, he or she must be enrolled in the School-Based Wellness Telemedicine Centers Program with the HCHD (separate enrollment form). In addition, the school nurse will always call you before your student/child receives any telemedicine services. If the nurse is unable to reach you, your student/child will be given the care normally provided by school health staff instead of telemedicine services, unless you have provided additional consent on the enrollment form for your child to have the telemedicine visit without the school nurse talking with you.

As part of the Telemedicine Center service, your student/child's personal health information will be shared among the HCPSS, the HCHD, and the telemedicine provider in order to coordinate care and deliver services. In addition, your student/child's personal health information may be used for treatment, payment, and operations as permitted under the privacy protections of the federal Health Insurance Portability and Accountability Act (HIPAA).

Please know that participation in this service is voluntary and is not required by Howard County Public Schools. If you choose not to participate, your student/child will receive care normally provided by school health staff. If you have questions, please contact your school.

By completing and signing this form, you: (1) agree that your student/child will participate in the School-Based Wellness Telemedicine Center Program; and (2) consent to the sharing of your student/child's personal health information among the HCPSS, the HCHD, and the telemedicine provider to the extent permitted under HIPAA.

Student/Child's Name: _____

School: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

Date: _____

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
TELEMEDICINE SERVICES

A partnership between the Howard County Health Department and the Howard County Public School System

What is telemedicine?
Telemedicine uses a secure, two –way video link between your school's health suite and their primary care provider or Howard County General Hospital Pediatric Emergency Room to provide acute health services to your child. Equipment operated by the HCPSS school nurse will send images and sounds to the provider. Your child can be seen and treated for pink eye, strep throat, rashes on exposed skin, ear infections, asthma flare ups, and other minor health conditions. If your child does not have a contagious condition and is well enough, he or she can be given medicine to make them comfortable and can remain in school. Prescriptions, if needed, are sent to the pharmacy of your choosing.

How can my child receive telemedicine services?
Children must be enrolled in the Howard County School-Based Wellness Center located inside your school's health suite to receive telemedicine services. The HCPSS school nurse will initiate and conduct the visit with the provider. Please visit the school's website or contact your HCPSS school nurse for information on how to enroll your child in this valuable program.

Will I know that my child is receiving telemedicine services?
Parents or guardians must enroll their children in the Howard County School-Based Wellness Center Program before the child can be seen. In addition, the HCPSS school nurse will call you before the child receives any telemedicine services. You may participate in the visit by remaining on the phone with the HCPSS school nurse or the provider can give you access to view the visit through your smart phone or computer. A copy of the visit will be sent home with your child.

If the nurse is unable to reach you, your student/child will be given the care normally provided by school health staff instead of telemedicine services, unless you have provided additional consent on the enrollment form for your child to have the telemedicine visit without the school nurse talking with you.

What if I can't participate in the visit? How will I know what is wrong with my child
A summary of the visit with the diagnosis and recommended treatment will be provided by the health provider treating your child. The HCPSS school nurse will print the summary, and this summary will either be given to your child to take home with the contact information of the provider in case you have questions or if your child's primary care provider saw your child, he or she will contact you with the visit information.

How will I billed for the telemedicine visit?
There are currently no fees or charges for a telemedicine visit if a Howard County General Hospital Pediatric Emergency Room physician sees your child. If your child is a patient at one of the practices listed below and a provider from that practice provides the telemedicine visit, then for these practices only, you will be billed as if your child saw their provider in their office. There is no additional cost for the telemedicine visit and your child will hopefully be able to remain in school.

Current Pediatric Providers participating in the Howard County Health Department telemedicine network (may be subject to change):

Columbia Medical Practice- Pediatrics
Ken Klebanow M.D. and Associates

For more information, please contact Sharon Hobson, School-Based Wellness Centers Program Administrator, at (410) 313-7238.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM
Parent/Guardian Consent Form

SCHOOL-BASED WELLNESS CENTERS TELEMEDICINE PROGRAM

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
Last Name:_____ **First Name:**_____ **Address:** _____ _____ *City State Zip Code* **Date of Birth:** _____/_____/_____ *Month Day Year* **Sex:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary: **Social Security Number (optional):** ___ - ___ - ___ **Race/Ethnicity** ☐Hispanic ☐Black ☐White ☐Native American ☐Asian/Pacific Islander ☐Other:_____ **Preferred Language:**_____ **Name of School:**_____ **Grade:**_____ **Health Insurance:** Does your child have health insurance? ☐ Yes ☐No If yes, does your child have Medical Assistance? ☐ Yes ☐No Does he or she have private insurance? ☐ Yes ☐No **If your child does not have health insurance, would you like staff from the Howard County Health Department contact and assist you with applying for health insurance?** ☐ Yes ☐ No	**Mother:** Last Name:_____First Name:_____ Contact Number(s):_____ Email Address:_____ **Father:** Last Name:_____First Name:_____ Contact Number(s):_____ Email Address:_____ **Legal Guardian, If Applicable:** Last Name:_____First Name:_____ Relationship of legal guardian to student:_____ ☐Grandparent ☐Aunt or Uncle ☐Other:_____ Contact Number(s):_____ E-mail Address:_____ **Additional Emergency Contact:** Name:_____ Relationship to the Student:_____ Home Tel:_____Work Tel:_____ Cell:_____

Please turn this page over, read the information, and sign and date on the three lines indicated. Please give the completed form to the school nurse. Thank you!

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL BASED WELLNESS CENTER TELEMEDICINE PROGRAM
Parent/ Guardian Consent Form

Child's Name: **School:**

SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals contracting with the Howard County Health Department (HCHD) which may include the primary health care provider I specified when enrolling my child in the HCHD School Based Wellness Center Program (SBWC) if the provider is part of the HCHD SBWC telemedicine network or another licensed health professional. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Wellness Center telemedicine services may include, but are not limited to:

- Medical care and treatment, including diagnosis of acute and chronic illness and disease
- Prescribing of medications and if ordered by licensed health provider and medically-indicated, the dispensing of acetaminophen, ibuprofen, hydrocortisone cream 1%, and albuterol via inhaler or nebulization on-site
- Medically prescribed, basic laboratory tests for strep throat (Rapid strep and throat culture)
- Referrals for service not provided at the school-based wellness center
- Health education and risk prevention counseling

X_____ _____

Signature of Parent/Guardian **Date**

HOWARD COUNTY HEALTH DEPARTMENT'S
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my child to release any medical or other information to assist in the management of my child's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:

Information Required by Law or School System:

- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

Information to Protect Health and Safety:

- Conditions which may require emergency medical treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity
- Health insurance coverage

PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, voluntarily consent to treatment of my child by the provider contracting with the Howard County Health Department to provide medical services at the School-Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

X_____ _____

Signature of Parent/Guardian **Date**

By signing below, I am granting permission for my child to have a telemedicine visit even if the school nurse is unable to contact me at the time of the visit. (1st Grade and older)

X_____ _____

Signature of Parent/Guardian **Date**

Time Period During Which Release of Information is Authorized:

From: Date the form is signed To: Date the student is no longer enrolled in the School-Based Wellness Center

Please make sure you have signed your name and dated the three lines on this page.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL-BASED WELLNESS CENTERS PROGRAM

Child's Name:	Today's Date:

FAMILY HEALTH INFORMATION

Does any of the child's family members (parents, sisters, brothers, grandparents) have or had the following:

Health Problem	Yes	No	Which Family Member?
Asthma			
Diabetes			
Mental Health/ Psychiatric Problem			
Sickle Cell			
Other:			

Who is the student's regular health provider?

Name: _____ **Office Telephone:** _____

Address: _____

When was your child's last physical or well child exam? _____
Date/Month

Please provide the name and phone number of your pharmacy.

Name: _____ **Phone Number:** _____

CHILD'S HEALTH INFORMATION

Please place a check in the box for any health problems your child has had.

- ☐ **Asthma** ☐ **Attention Deficit Disorder** ☐ **Bleeding Problems** ☐ **Depression**
- ☐ **Diabetes** ☐ **Ear Infection** (frequent) ☐ **Epilepsy/Seizures** ☐ **Headache** (frequent)
- ☐ **Hearing** ☐ **Heart Problems/Murmur** ☐ **Rheumatic Fever** ☐ **Sickle Cell Anemia**
- ☐ **Tuberculosis** ☐ **Vision** ☐ **Other:** _____
- ☐ **Allergies (List all, including medicines):**

If your child has been hospitalized, please provide the date(s) and reason(s):

Medical and Family History Questionnaire

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOUR CHILD TAKES: _____

_____

MARYLAND DEPARTMENT OF HEALTH
AND YOUR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES

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

Introduction

The Maryland Department of Health (MDH) is committed to protecting your health information. MDH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your health care, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. MDH and its Business Associates are required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any MDH agency. It is also posted on our website at https://health.maryland.gov/pages/index.aspx

Permitted Uses & Disclosures

MDH employees will only use your health information when doing their jobs. For uses beyond what MDH normally does, MDH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions. The following are some examples of our possible uses and disclosures of your health information:

Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:

- **For treatment:** MDH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, MDH health care providers may need to review your treatment with your health care provider for medical necessity or for coordination of care.
- **To obtain payment:** MDH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** MDH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures of Health Information Required or Permitted by Law:

- **Information purposes:** Unless you provide us with alternative instructions, MDH may send appointment reminders and other materials about the program to your home.
- **Required by law:** MDH may disclose health information when a law requires us to do so.
- **Public health activities:** MDH may disclose health information when MDH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.
- **Health oversight activities:** MDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** MDH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes**: In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, MDH may disclose health information to assist medical research.

- **Avert threat to the health or safety:** In order to avoid a serious and imminent threat to health or safety, MDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** MDH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. MDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** MDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **Family, friends, or others involved in your care:** MDH may share your health information with people as it is directly related to their involvement in your care or payment of your care. MDH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** MDH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** MDH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a MDH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, MDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** MDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** MDH may conduct the above-described activities ourselves, or we may use non-MDH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** MDH may use information about you to contact you in an effort to raise money for MDH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at MDH.

Your Rights

You Have a Right to:

- **Request restrictions:** You have the right to request a restriction or limitation on the health information MDH uses or discloses about you. MDH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, MDH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that MDH send you information at an alternative address or by alternative means. MDH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the PHI. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If MDH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that MDH correct or add to your health record. MDH will respond to your request within 60 days, with up to a 30-day extension, if needed. MDH may deny the request if MDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If MDH approves the request for amendment, MDH will change the

health information and inform you, and MDH will tell others that need to know about the change in the health information.

- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, MDH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year. Additionally, MDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to opt-out of a MDH facility's patient directory, and you have the right to opt-out of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System for our Patients (CRISP).
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information**: If any of MDH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, MDH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

For More information:
This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact **Antigone Vickery, Deputy Health Officer, Howard County Health Department at 410-313-6300.**

To Report a Problem about our Privacy Practices:
If you believe that your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Maryland Department of Health, Division of Corporate Compliance at 1-866-770-7175.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. You may call the Maryland Department of Health for the contact information.

MDH will take no retaliatory action against you if you make such complaints.
Effective Date: This notice is effective on July 1, 2017.

(Provider programs must ensure that they try to get this acknowledgement signed)
Acknowledgement of receipt of this notice:

_____ _____
Patient or Authorized Representative Date

If unable to get acknowledgement, specify why:

_____
Signature of MDH representative