Safeguarding Your Protected Health Information

BCDH is committed to protecting your health information. BCDH is required by law to maintain the privacy of your health information, and to provide you with this notice of our legal duties and privacy practices with respect to your health information, and to follow the privacy practices described herein.

BCDH reserves the right to change our privacy practices and the terms of this Notice at any time, and to apply the provisions of the revised Notice to your health information that we obtained before revising the Notice. If this occurs, we will post the current version on our website and make it available to you at our service locations. You may obtain a copy of the Notice currently in effect by calling 410-887-3077. The current Notice is also posted on our website: www.baltimorecountymd.gov/go/hipaa

To Report a Problem about our Privacy Practices

If you believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Privacy Officer by calling 410-887-3077.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the County’s Privacy Officer for the contact information.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Effective Date: September 23, 2013

Notice of Privacy Practices

Baltimore County Department of Health (BCDH) and Associated Entities

You have the right to:

Breach Notification: You have the right to be notified of a breach involving your information.

Request Restrictions: You have a right to request a restriction or limitation on the health information BCDH uses or discloses about you. BCDH may accommodate your request, if possible, but is not legally required to agree to the requested restriction. If BCDH agrees to a restriction, BCDH will follow it except in emergency situations. You have the right to request that we not share your information about a particular visit with your insurance company as long as you have paid the entire charge yourself.

Request Confidential Communications: Our normal method of contacting you is by mail to your home address and via the phone numbers you provide. You have the right to ask that BCDH send you information at an alternative address or by alternative means. BCDH must agree to your request as long as it is reasonable for us to do so.

Review and/or Request a Copy: You have a right to review or request a copy of your health information. If your health information or a portion thereof is in paper-only format, there may be a copying and postage fee. You have a right to request that portions of your information you want copied and receive an estimate of the cost. If your records are in electronic format, you may request your information in electronic form and additionally may request that we transmit a copy of that information to a third-party. The request for electronic copy and transmittal to a third party must be requested in a clear, conspicuous and specific manner. We may charge a fee based on cost of labor to produce the electronic copy.

Request Amendment: You may request in writing that BCDH correct or add to your health record. BCDH may deny the request if BCDH determines that the health information is: (1) correct and complete; (2) not created by

us and/or not part of our records; or (3) not permitted to be disclosed. If BCDH approves the request for amendment, BCDH will change the health information and inform you, and will inform others that need to know about the change in health information.

Accounting of Disclosures: You have a right to request a list of the disclosures made of your health information for the six year period prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and operations. In addition, BCDH does not have to list disclosures made to you, to others when based on your written authorization, when provided for national security, or when provided to law enforcement officials and correctional facilities. Additionally, BCDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to the three year period prior to date of request. There will be no change for up to one such list each year.

Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request. You have the right to request that this Notice in alternate format by contacting the Office of Communications and Constituent Services by calling 410-887-6092.

How to exercise your rights:
Submit your request in writing to:

Privacy Officer
Baltimore County Department of Health
6401 York Road, Third Floor
Baltimore, MD 21212

Other important information: If you have questions and would like more information, you may contact the Privacy Officer at 410-887-3077. TTY users, call via Maryland Relay.

You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights.

You can file a complaint with the Privacy Officer by calling 410-887-3077.

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Effective Date: September 23, 2013
How BCDH May Use and Disclose Your Protected Health Information

All services you receive from BCDH programs, regardless of type or location, are legally considered a single record. BCDH employees will only use your health information when doing their jobs. For use and disclosures beyond those described in this Notice, BCDH must have your written authorization. If you give such authorization you may revoke it by notifying the Privacy Officer at the address listed at the end of this section. This revocation shall apply except where we have already used or disclosed information in accordance with the authorization. The following are some examples of our possible uses and disclosures of your health information.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations:

For Treatment: BCDH may use or share your health information to provide treatment or arrange for health-related services. Some examples are:

- use your information to contact you regarding services offered by the Health Department, but you have the right to refuse additional services that you may not want at the time.
- To obtain payment or make arrangements for payment of a health service: BCDH may use and share your health information in order to obtain an authorization from your insurance company or to submit a health care claim. We may also coordinate health insurance benefits between insurance carriers. In certain cases, we may pay for certain medications or other supplies or services.

For Health Care Operations: BCDH may use and share your health information to evaluate the quality of services we provide and to help maintain the high quality of those services. For example, we may use your information to evaluate our treatment and services which have been provided. We may combine health information about many individuals to research health trends, to determine what services should be offered, or for other similar uses. We may also share your health information with state or federal auditors, as required by law or regulation.

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

Vaccination Documentation Required for School Entry: We may share your vaccination information with a public or private school after obtaining your verbal permission.

Public Health Authority: BCDH operates as a Public Health Authority as well as a health care provider. In our role as a Public Health Authority, we may use your health information to investigate and track diseases as required by law. This function is exempt from the Health Insurance Portability and Accountability Act (HIPAA) requirements.

Information Purposes: Unless you provide us with alternative instructions, BCDH may send appointment reminders and other materials about a particular program to your home.

Required by Law: BCDH may disclose health information when a state or federal law requires us to do so.

Public Health Activities: BCDH may disclose health information when BCDH is required to collect or report information about disease or injury, or to report vital statistics to other divisions in the department and other public health authorities.

Health Oversight Activities: BCDH 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.

Workers’ Compensation: BCDH may disclose your health information to workers’ compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.

Law Enforcement: BCDH may disclose your health information to law enforcement officials for purposes that are required by law or in response to a law enforcement official's request.

Contact the Privacy Officer:

Privacy Officer
Baltimore County Department of Health
6401 York Road, Third Floor
Baltimore, MD 21212
I am granting permission for my child to enroll in the School-Based Wellness Center and consent to them receiving health related services which can include physical examinations, health screenings, limited diagnostic tests, education, counseling, referrals, and administration of necessary medications. I understand the school nurse may participate in coordinating follow-up care and will have access to the Wellness Center records. You have my permission to release any Wellness Center health information to any health or mental health professional providing services to my child through the Wellness Center, school health suite, or school counseling office. You have my permission to release any educational information to any health or mental health professional who needs this information to care for my child through the Wellness Center.

- My signature on this consent certifies that I have received Baltimore County Department of Health Notice of Privacy Practices.
- I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, contraception, drug use, and mental health (12 years of age or older).
- I understand that I am responsible for medical care if follow-up outside the school-based center is recommended.
- I authorize the release of any medical or other information necessary to process insurance claims, if applicable.
- I authorize payment of medical benefits to Baltimore County for services rendered at the Wellness Center.
- I agree that if I receive payment from my insurance company for services rendered at a Wellness Center, I will endorse the check and forward it to the Wellness Center. I understand that if my child has health insurance through Medical Assistance, with or without a Managed Care Organization (MCO), they can still receive care from the Wellness Center.
- I understand that my child’s immunization record will be entered on the Maryland registry, ImmuNet, if vaccines are given.

Print Child’s Name __________________________ Birth Date __________________________ Grade __________________________
Address __________________________ Zip __________________________
Child’s Social Security Number __________________________
Child’s Health Care Provider __________________________ Telephone __________________________
Print Name of Parent/Guardian __________________________
Mother’s Maiden Name __________________________
Relationship to Student __________________________
Telephone (H) (W) __________________________ Date __________________________
Signature of Student __________________________ Date __________________________
Signature of Parent/Legal Guardian __________________________ Date __________________________

IF YOUR CHILD HAS ANY FORM OF HEALTH INSURANCE, PLEASE PROVIDE A COPY OF THEIR INSURANCE CARD.

IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:
Child’s Medical Assistance Number: __________________________
Child receives MA services through an MCO? YES ______ NO ______
If YES, name of MCO __________________________ Policy/Contract# __________________________ Effective Date: __________________________

IF YOUR CHILD’S HEALTH CARE IS COVERED BY PRIVATE INSURANCE, PLEASE COPY ALL THE FOLLOWING INFORMATION DIRECTLY FROM YOUR INSURANCE CARD:
1. Insurance Company’s Name & Address __________________________ City __________________________ Zip __________________________
   Insurance Company’s CLAIMS (Billing) Address (if different from above) __________________________
   City __________________________ Zip __________________________
   Insurance Company’s Phone Number __________________________
2. Name of Individual listed on Insurance Card __________________________
   Policy Number of Insured Listed on Card __________________________
   Group Number Listed on Health Insurance Card __________________________
3. List the name of the Policy Holder (person whose name the insurance policy is under) __________________________
   Social Security Number of Policy Holder __________________________
   Place of Employment of Policy Holder __________________________
   Work Phone Number ( ) __________________________
   Relationship of Policy Holder to Child __________________________
   Home Address of Policy Holder __________________________

IF YOUR CHILD HAS NO HEALTH CARE COVERAGE, PLEASE INDICATE BY PLACING A ( √ ) HERE ( ) AND COMPLETE BELOW.

Please indicate Annual Income: __________________________ Number of Family Members: __________________________

If you need help with Medical Assistance, please call the Maryland Health Connection 1-855-642-8572
Wellness Center
Health/Family History Questionnaire
(To be completed by Parent/Guardian)

Date of child’s last physical examination:______/______/______

Student Name:________________________
Date of Birth:________________________
Sex: (circle) Male □ Female □ Other □

Forms Competed by:________________________
Relationship:________________________
Today’s Date:________________________

<table>
<thead>
<tr>
<th>PREGNANCY AND BIRTH HISTORY</th>
<th>PSYCHOSOCIAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illnesses/medications during pregnancy? No □ Yes □</td>
<td>Who lives in household? Mother □ Father □</td>
</tr>
<tr>
<td>Alcohol/Drug use? No □ Yes □</td>
<td>Siblings □ Grandparent/s □ Other children □</td>
</tr>
<tr>
<td>Problems at birth? No □ Yes □</td>
<td>Other Adults □ How many? □</td>
</tr>
<tr>
<td>Describe: ______________________________</td>
<td>Rent? □ Own? □ Shelter? □</td>
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<tr>
<td>Did child stay in intensive care nursery after birth? No □ Yes □</td>
<td>Who cares for child during the day?________________</td>
</tr>
<tr>
<td>Why? ________________________________</td>
<td>Are parents working? Mother No □ Yes □</td>
</tr>
<tr>
<td>Type of Delivery? Vaginal □ C-Section □</td>
<td>Father No □ Yes □</td>
</tr>
<tr>
<td>If C-section, why________________________</td>
<td>Foster Care? __________ Dates:________________</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>YOUR CHILD’S MEDICAL HISTORY</th>
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</thead>
<tbody>
<tr>
<td>Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers) had:</td>
<td>Has your child ever had:</td>
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<tr>
<td>Asthma □ □ □</td>
<td>Asthma □ □ □</td>
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<tr>
<td>TB/Lung Disease □ □ □</td>
<td>Chicken Pox (Month/Yr) □ □ □</td>
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<tr>
<td>HIV/AIDS □ □ □</td>
<td>Frequent Ear Infections □ □ □</td>
</tr>
<tr>
<td>Suicide Attempts □ □ □</td>
<td>Vision/Hearing Problems □ □ □</td>
</tr>
<tr>
<td>Heart Disease □ □ □</td>
<td>Skin Problems/Eczema □ □ □</td>
</tr>
<tr>
<td>High Blood Pressure/Stroke □ □ □</td>
<td>TB/Lung Disease □ □ □</td>
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<tr>
<td>High Cholesterol □ □ □</td>
<td>Seizures/Epilepsy □ □ □</td>
</tr>
<tr>
<td>Blood Disorders/Sickle Cell □ □ □</td>
<td>CP/Meningitis □ □ □</td>
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<tr>
<td>Diabetes □ □ □</td>
<td>High Blood Pressure □ □ □</td>
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<tr>
<td>Seizures □ □ □</td>
<td>Heart Defects/Disease □ □ □</td>
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<tr>
<td>Mental Illness/depression □ □ □</td>
<td>Liver Disease/Hepatitis □ □ □</td>
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<tr>
<td>Cancer □ □ □</td>
<td>Diabetes □ □ □</td>
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<tr>
<td>Birth Defects □ □ □</td>
<td>Kidney Disease/Bladder □ □ □</td>
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<tr>
<td>Hearing Loss □ □ □</td>
<td>Infections □ □ □</td>
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<tr>
<td>Speech Problems □ □ □</td>
<td>Speech or Learning Disabilities □ □ □</td>
</tr>
<tr>
<td>Kidney Disease □ □ □</td>
<td>Physical Limitations □ □ □</td>
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<tr>
<td>Alcohol/Drug Abuse □ □ □</td>
<td>Bleeding Disorders/Hemophilia □ □ □</td>
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<tr>
<td>Hepatitis/Liver Disease □ □ □</td>
<td>Sexually Transmitted Infections □ □ □</td>
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<tr>
<td>Thyroid Disease □ □ □</td>
<td>Emotional or Behavioral Problems □ □ □</td>
</tr>
<tr>
<td>Learning Problems/ Attention Deficit Disorder □ □ □</td>
<td>Depression/Suicidal Thoughts □ □ □</td>
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<tr>
<td>Family Violence □ □ □</td>
<td>Hospitalizations/Surgeries □ □ □</td>
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<tr>
<td>Any other family health history □ □ □</td>
<td>Physical/Emotional/Sexual Abuse □ □ □</td>
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<tr>
<td>concerns: ______________________________</td>
<td>Bone or Joint Injuries □ □ □</td>
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<tr>
<td>□ □ □</td>
<td>Obesity/Eating Disorders □ □ □</td>
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<tr>
<td>□ □ □</td>
<td>Other: _____________________________</td>
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</tbody>
</table>
| □ □ □ | Current Medication(s): (List) __________________

Reviewed by:________________________
Date of Review:________________________