MONROE CITY SCHOOL DISTRICT

and

Clarity Healthcare/Preferred Family Healthcare, Inc.

Shared Consent to Treat and Record Disclosure

Patient Name:	
SS#:	DOB:
Address:	
Phone #:	Alternate Phone #:

_____Yes, I consent for above child to receive health care services through Clarity Healthcare/Preferred Family Healthcare, Inc. via telehealth located at Monroe City School District.

_____Yes, I consent to allowing Monroe City School District and Clarity Healthcare/Preferred Family Healthcare, Inc. to share and receive medical and mental health information for the purpose of continuity of care and treatment. I understand that all information exchanged by these persons within these two agencies is confidential and will not be disclosed to any other party without the prior written consent of the parent or legal guardian except as permitted by law. The parent or legal guardian may revoke this release of information at any time by submitting the request in writing to Clarity Healthcare.

_____Yes, I understand that information exchange by these persons or agencies may be used only for educational, medical, and mental health decisions for the individual child listed above. The above child may not have access to certain services if this release of information is not authorized.

- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I consent to allow Clarity Healthcare/Preferred Family Healthcare, Inc. to obtain emergency medical or psychiatric treatment and/or medical services deemed necessary for my physical and mental health unless otherwise specified through written consent. I understand that I will be responsible for costs not covered under insurance benefits for these services.
- I authorize the release of medical and billing information from Clarity Healthcare/Preferred Family Healthcare, Inc. for the purpose of payment collection; including the release of drug abuse (if applicable) information that may be contained in the records. Authorization includes the release of preadmission, recertification and appeal information to insurance companies for their agents which may include diagnosis, symptoms, treatment plans, test results or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable).
- I consent to allow Clarity Healthcare/Preferred Family Healthcare, Inc. to report communicable diseases as outlined by the Missouri Department of Health and Senior Services to that agency and to cooperate with investigations, providing client information as requested.
- By signing this consent, I confirm I am the parent or legal guardian of above child, and am authorized to give this consent. I understand I may revoke this consent at any time with a written request.

Signature:	Date:

If you would like a copy of this authorization, please initial: _____Yes _____No Witness Initials:_____