HEALTHY BEGINNINGS

Community Health and Development Screening INTAKE/RELEASE/PERMISSION

Date ____________________
Apt Time: ________________
I.D. No. ________________

How did you learn about the screening? ______________________ Child's Ethnicity/Race: ____________________________

Child's Name: ______________________________ M / F DOB: __________ Premature: Y / N Weeks Early: __________
(2 years or younger only)

Parent/Guardian _______________________________ Phone ____

Mailing Address ____

Email Address ____Preferred method of contact: Call / Text / Email

Insurance: Private | OHP | None Vision Insurance Coverage Y / N Regular Doctor: Y / N Medical Home/Doctors Office: ______________________ Regular Dentist Y / N Vision Exam w/Eye Doctor Y / N Developmental screening in last 12 months? Y / N If so, where? ____ Concerns? ____	Library card? Y / N Enrolled in Head Start? Y / N Receives services from: EI/ECSE (Early Intervention)? Y / N WIC: Y / N CASA: Y / N MountainStar Family Relief Nursery Y / N Dept. of Human Services (Food Stamps / TANF) Y / N Dept. of Human Services (Foster Care / Child Welfare) Y / N Saving Grace Y / N | KIDS Center Y / N

RELEASE: I release the Healthy Beginnings Board of Directors and the sponsoring organizations as well as High Desert Education Service District, Central Oregon Regional Programs, Healthy Families of the High Desert, all medical professionals, lay volunteers and the owners of the building site from any and all liability which may arise during this screening. **I understand that the screening in no way provides conclusive results and should not be considered in any way a diagnosis.** If a referral is made from Healthy Beginnings, I will seek a medical opinion or an in-depth evaluation from an early childhood development specialist. I understand I must stay with my child at all times for safety purposes.

This screening does not take the place of a medical, dental, vision, hearing or other health related exam.

In giving written permission below, I understand that:

1. The information from this screening is to be considered as preliminary only and in no way is intended to take the place of a complete examination or evaluation by a physician, dentist or early childhood development specialist. **Healthy Beginnings is not a diagnostic service but solely a referral service.**
2. The responsibility of follow-up examinations and evaluations for health or development concerns identified at the screening lies with me as the parent responsible for my child's health and not with any participating organization.
3. Several of the above-mentioned organizations are given access to my child's test results for the sole purpose of determining if the results indicate a concern and to counsel me in initiating a follow-up exam or evaluation. No other individual or agency will be given access to my child's test results without written permission from me.
4. Sponsoring organizations are not liable for any accidents occurring during this screening in or around the buildings.
5. I understand that all information about my family is confidential and will only be shared by Healthy Beginning's staff and those early childhood agencies authorized by me. The staff of Healthy Beginnings has a mandatory obligation according to [ORS 419B.005-419B.045] to report any suspicion of child abuse or neglect, any plan for self-harm or any plan for criminal behavior that may place a child in harm to the proper authorities.

PERMISSION: I give my permission for _________________ to participate in this screening. I understand that my consent is voluntary and that it may be revoked at any time during the screening.

____
Signature (parent/guardian) Date

____
Signature of Witness Date

I give permission for Healthy Beginnings to release my child's screening results to the following:

Name of Facility

____

Parent/Guardian Signature:_________________________

Note: If sharing with Primary Care Doctor, signature required on HIPAA form on reverse side.

1029 NW 14th Street ♦ Bend, Oregon 97703 ♦ Ph: 541-383-6357

AUTHORIZATION FOR USE OR DISCLOSURE OF SCREENING RESULTS AND INFORMATION BETWEEN HEALTHY BEGINNINGS AND HEALTH CARE PROVIDERS

Completion of this document allows the disclosure and/or use of individual identified education records and health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Child Name: ____

Last First MI Date of Birth

I, the undersigned, do hereby authorize **Healthy Beginnings** to provide screening results and information from the above-named child's screening record to and from:

______________________________ ______________________________

Primary Care Provider to Which Disclosure is Made Address/City and State/Zip

______________________________ ______________________________

Contact Person at Primary Care Provider Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

____

Description of Information to be Disclosed: I authorize the release and disclosure of any and all screening records, histories, reports, notes, and all such other assessment information pertaining to ______________________ [Name of Child] , a minor, of whatever kind and character, and including but not limited to any screening protocols, summary form, intake form and records, from [Date] to the date this release is presented for such records, to the persons/entities identified herein.

DURATION:

This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature, unless sooner revoked by me in writing.

RESTRICTIONS:

Law prohibits the Primary Care Provider from making further or different disclosure of the health information contemplated by this Consent form unless another authorization form is obtained from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

RE-DISCLOSURE:

I understand that the Primary Health Care Provider will not improperly disclose this information, as prescribed by the Healthcare Information Privacy Protection Act (HIPPA) and that this information becomes part of the child's medical records. The information will be shared with individuals working at or with the Primary Health Care Provider for the purpose of providing health services and appropriate referrals.

I have a right to receive a copy of this Authorization. Signing the Authorization may be necessary in order for this student to obtain appropriate services from their Primary Health Care Provider.

APPROVAL:

______________________ ______________________ ______________

Printed Name Signature Date

______________________ ______________________

Relationship to Child/Student Area Code and Telephone Number