NOTICE: During the remote learning period, the school-based health center will be open to students for in-person and phone appointments.

SEATTLE PUBLIC SCHOOLS

2020–2021 SCHOOL YEAR

Dear Parents/Guardians:

Your student's health is an important part of their academic success. In order to support that success, Madison Middle School has a school-based health center (SBHC) on site available to all students for both in-person and telehealth visits. The SBHC is operated by Neighborcare Health, a community health center serving more than 71,000 people in Seattle and Vashon Island each year.

The SBHC offers a child-friendly setting and all the services of a family doctor without leaving the school. The SBHC provides appointments before, during and after school. Even if your student already has a care provider, we can work closely with them, providing a convenient option for medical, dental, and mental health services at school.

To use SBHC services, please complete and sign the following forms in this packet:

- ❑ **Health History Form (pg. 2)**
- ❑ **Registration Form (pgs. 3-4)**
- ❑ **Consent Form (pg. 5)**
- ❑ **Dental Screening Consent (pg. 6)**
- ❑ **Release of Education Records Form (pg. 7) (Optional)**

Forms can be returned with the school packet or mailed to the school separately. They can also be dropped off in person at the SBHC or the school's main office.

Release of Education Records: This form allows your child's school records to be shared with Neighborcare Health. Access to school records enables Neighborcare Health to work with teachers and staff to improve student learning, attendance, grades and behavior.

Cost of Services: Neighborcare Health is committed to serving all patients regardless of ability to pay. The Madison Middle School SBHC receives support from the Families and Education Levy, but this funding does not fully cover the program's operating costs; therefore the SBHC bills insurance when appropriate. Please complete the insurance section of the registration form to ensure that we have your most current insurance information on file.

If you do not have health insurance, the SBHC can help you enroll in an insurance plan. Please check the "No Insurance" box on the registration form and a SBHC staff member will follow-up with you. You can also call the SBHC directly to request health insurance enrollment assistance.

Madison Middle School is fortunate to have the SBHC and I hope you will take advantage of this resource for your child. If you would like more information or need assistance please call the Madison Middle School SBHC at 206-933-7842.

Sincerely,

R. Gary
Principal

If you would like a translated copy of this information, please visit www.neighborcare.org

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER

HEALTH HISTORY FORM

neighborcare health

Please complete this form to help us provide your child with quality care. Your child will be invited to the health center for a health screening to review their weight, height, blood pressure and immunization history, and complete a health risk assessment. The health center will contact you about any recommendations for supporting your child's health and readiness to learn. Additional consent from a parent/guardian is required before giving any vaccines. Please contact the health center if your child has a health issue and needs an appointment.

STUDENT	First Name	Last Name	Date of Birth / /
Printed Name of Person Completing Form		Relationship to Student (if not self)	Date Form Completed / /
Best Phone Number to Reach you		Best Time to Call	

QUESTIONS ABOUT YOUR CHILD:

❑ Yes ❑ No Does your child have a primary care doctor or clinic?
Provider Name: Clinic: Phone:

❑ Yes ❑ No Has your child had a well child check up or full physical in the past year?

❑ Yes ❑ No Has your child seen a dentist in the past year?

❑ Yes ❑ No Does your child have any medication or other allergies?
(Describe):

❑ Yes ❑ No Does your child take any medications? (Include vitamins and over-the-counter medications.)

Medication	Dosage	Reason

❑ Yes ❑ No Does your child have any ongoing health problems or current health concerns?
(Describe):

❑ Yes ❑ No Has your child ever stayed in a hospital or had surgery?
(Describe):

❑ Yes ❑ No Does your child have any school/learning needs or concerns?
❑ Attendance problems ❑ Worse or failing grades ❑ Special Education ❑ Other:

❑ Yes ❑ No Do you have other concerns about your child's well being? (ex: too much worry, stress, depression, anxiety, etc.)
(Describe):

QUESTIONS ABOUT YOUR FAMILY:

Who lives in your home?

If your child also lives in another home, who lives there?

❑ Yes ❑ No Have there been any major changes or challenges in your family in the past year?
If yes, describe:

❑ Yes ❑ No Does anyone living with your child smoke cigarettes, cigars, e-cigarettes, or marijuana?

❑ Yes ❑ No Are you concerned there will not be enough food or money to feed your family?

❑ Yes ❑ No Is there a gun in your home? If yes, is it locked? ❑ Yes ❑ No

❑ Yes ❑ No Is your child adopted?

FAMILY HEALTH HISTORY (*Check all that apply*)

Family Member	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems
Mother														
Father														
Other Family Member:														
Other Family Member:														

Is there any other family history of disease or chronic illness?

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER

PATIENT REGISTRATION FORM

neighborcare health

Please fully complete this form to help us provide your child with quality care. This consent will remain active from year to year. Please submit a request in writing to withdraw consent for services.

Please complete sections 1–6.

1. STUDENT INFORMATION AND DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST

STUDENT ID NUMBER	DATE OF BIRTH / / MONTH DATE YEAR	BIRTH SEX ❑ Male ❑ Female	LEGAL SEX ❑ Male ❑ Female ❑ Nonbinary

MAILING ADDRESS	APT	SECONDARY ADDRESS (if different)	APT

CITY	STATE	ZIP	CITY	STATE	ZIP

PARENT PHONE ❑ Home ❑ Mobile ❑ Work ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	STUDENT PHONE ❑ Home ❑ Mobile ❑ Work ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___
PARENT E-MAIL ADDRESS	STUDENT E-MAIL ADDRESS
APPOINTMENT NOTIFICATION PREFERENCE (choose one) PARENT ❑ Text ❑ Phone Call ❑ MyChart	APPOINTMENT NOTIFICATION PREFERENCE (choose one) STUDENT ❑ Text ❑ Phone Call ❑ MyChart

GENDER IDENTITY	❑ Female ❑ Male ❑ Questioning	❑ Transgender Male to Female ❑ Transgender Female to Male ❑ Nonbinary/Gender Queer	❑ Other _____ ❑ Choose not to disclose
SEXUAL ORIENTATION	❑ Straight ❑ Gay	❑ Lesbian ❑ Queer	❑ Bisexual ❑ Pansexual	❑ Other:_____ ❑ Choose not to disclose
PREFERRED PRONOUN	❑ She, Her, Hers ❑ He, Him, His	❑ They, Them, Theirs ❑ Other:	❑ Choose not to disclose
ARE YOU HISPANIC OR HISPANIC-LATINO?	❑ Yes, Hispanic or Latino	❑ Not Hispanic or Latino	❑ Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ More than one race	❑ Asian ❑ Other Pacific Islander ❑ Declined to identify	❑ Black/African American ❑ White
ARE YOU A US VETERAN?	❑ Yes ❑ No		
WHAT IS YOUR EMPLOYMENT STATUS?	❑ Full Time ❑ Part Time ❑ Seasonal	❑ Child ❑ Not Employed ❑ Active Military Duty	❑ Self Employed ❑ Retired ❑ Student
WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?		DO YOU NEED AN INTERPRETER?	❑ Yes ❑ No

2. PARENT/GUARDIAN (IF PATIENT IS UNDER 18)

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME	DATE OF BIRTH / /	SEX ❑ Male ❑ Female

MAILING ADDRESS	APT	RELATIONSHIP TO PATIENT ❑ Parent ❑ Guardian ❑ Other

CITY	STATE	ZIP	PHONE ❑ Home ❑ Mobile ❑ Work ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

This form continues on reverse. Please complete all sections. ➲

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER
PATIENT REGISTRATION FORM

neighborcare health

Continued from reverse.

3. INSURANCE

DO YOU HAVE INSURANCE?	❑ Yes ❑ No			
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE		EFFECTIVE DATE	
	GROUP PLAN NUMBER		MEMBER ID #	
	SUBSCRIBER/POLICY HOLDER NAME		SUBSCRIBER DATE OF BIRTH	
ARE YOU INTERESTED IN OUR SLIDING FEE DISCOUNT PROGRAM?	We offer a sliding fee discount if you do not have health insurance or need help paying for expenses that health insurance does not cover. Eligibility for the program and the minimum fee is based on your family size and income. For more information and to apply, would you like to meet with one of our eligibility specialists?		❑ Yes ❑ No	

4. ADDITIONAL QUESTIONS (Answer for patient or, if patient is a minor, please answer for legal guardian.)

YEARLY OR MONTHLY INCOME	What is your household's annual (yearly) gross income?	$	If easier to calculate, what is your household's monthly income?	$
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return:			
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	❑ Not Homeless ❑ Doubling Up ❑ Other ❑ Permanent Supportive Housing ❑ Public Housing ❑ Shelter ❑ Street ❑ Transitional			
MIGRANT/SEASONAL WORK STATUS	At any point in the past two years, has seasonal or migrant farm work been your or you family's main source of income?		❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work	
HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (Mark all that apply)	❑ Friends or family ❑ Insurance ❑ Online search (Google) ❑ Other non-Neighborcare provider ❑ Convenient location/close to home ❑ Other community group or program ❑ Social media (Facebook, Twitter, Instagram) ❑ Ads (billboard, bus, newspaper) ❑ School ❑ Other			

5. PRIVACY NOTICE

I hereby acknowledge I have received Neighborcare Health's Notice of Privacy Practices. I understand Neighborcare Health may contact me about appointment reminders, test results, treatment options or other health related benefits and services via phone call, text message, e-mail, or voicemail.	Initials

6. RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to Neighborcare Health is currently correct, and I understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the medical, mental health and dental staff to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problem(s). I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by a Licensed Social Worker, Licensed Mental Health Counselor, or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is canceled by written notice to the Chief Medical/Dental Officer. The assignment and release authorizes Neighborcare Health to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly any benefits of any policies of insurance to those health care providers who have rendered services to me. I agree to pay in full all charges that are not paid in full by assigned insurance.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE
		/ /

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER
CONSENT FOR HEALTH SERVICES

neighborcare health

Neighborcare Health's school-based health centers are located in Seattle Public Schools and the Vashon Island School District. Neighborcare Health must have signed consent from a parent or legal guardian before providing services, except in situations where federal or state laws allow the student to access treatment without parent/guardian consent. Students do not need to be registered at the health center to receive services from the school nurse.

I hereby request and authorize that: (Print student's name below.)

First Name	Middle Initial	Last Name	Date of Birth
			/ /

receive health care services available from and deemed necessary by the Neighborcare Health SBHC staff. These services may include, but are not limited to: mental health counseling, routine medical exams, naturopathy, sports physicals, well-child or teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, dental and fluoride treatment services. SBHC staff encourage family involvement in the care they provide to students. However, if I am unable to be present, authorization is given for my child to receive services in my absence. This care may occur both in-person or remotely via phone or virtual telehealth visit. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the Neighborcare Health SBHC staff. This authorization does not allow services to be rendered without the student's consent, unless the student is unable to consent. Neighborcare Health is committed to creating a health care home that includes medical, dental and mental health care and Neighborcare Health encourages long-term relationships between patients and providers. Neighborcare Health collaborates with other providers in the community that may also be seeing the patients we serve to ensure care is coordinated.

In accordance with state and/or federal law, when consent is provided for care, health care information is kept confidential. A few exceptions exist; for example:

1. Permission is given by the patient or parent/guardian through a signed release of information form.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under the age of 18.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care providers at the SBHC, including exchange of information between the mental health therapist, nurse practitioner or physician assistant and the school nurse, for the purpose of providing the best care for the above named student. To facilitate coordination of care, the student's SBHC medical record will be accessible to Neighborcare Health staff at the SBHC. Consent is granted for the school nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the medical provider of the SBHC.

Students may also receive health services independently at any of Neighborcare Health's medical or dental clinics. With this consent, services can be received at any Neighborcare Health medical and dental clinic. To see a list of clinic locations, please visit our website at neighborcare.org. To schedule an appointment, call the Neighborcare Patient Contact Center at 206-548-5710.

Consent is authorized for services provided by Neighborcare Health during the length of time the student is enrolled in a school with a Neighborcare Health SBHC or for the length of time services are provided at another Neighborcare Health clinic. Withdrawal of this consent can be done at any time by writing to the SBHC.

Student Signature: *(Required for 13 and older)*	Date: / /
Parent/Guardian Signature:	Date: / /
Name of Legally Responsible Guardian (Print):	Relationship:

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages students to involve their parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent."

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER
DENTAL SCREENING CONSENT

neighborcare health

SCHOOL:	CLASSROOM #:	MRN: (For Administrative Use)

DEAR PARENT OR GUARDIAN:

We are offering dental screenings in your child's school to inform you about your child's dental health. The screenings have **no out of pocket cost to you.**

If you agree to have us screen your child:

- Dental screenings will resume when students return for in-person learning.
- We will be happy to give you information to make a dental appointment, or make an appointment for you, if you need a dental provider.
- We will send you a copy of your child's results. This information may be shared with your child's school.
- We may leave a message on your phone if we need to contact you about your child's dental needs.

WHAT IS A DENTAL SCREENING?

A Neighborcare Health dental provider will look at your child's teeth and make a **visual evaluation.**

They will apply a **fluoride varnish** which is a protective coating that is painted on teeth to help prevent new cavities and to help stop cavities that have already started.

A dental screening **does NOT take the place of a complete dental exam** by your child's dentist.

Parents or Guardians, please fill out the information below and sign the bottom of the form.

NAME OF STUDENT:			
FIRST NAME	MI	LAST NAME	DATE OF BIRTH / /
GENDER OF STUDENT: ❑ Male ❑ Female ❑ X			

NAME OF PARENT/GUARDIAN:			
FIRST	MI	LAST	DATE OF BIRTH / /
ADDRESS:		CITY:	ZIP:
PHONE #:			

Do you prefer to be contacted in a language other than English?	❑ No ❑ Yes	If yes, what language?
How would you like to receive your child's dental evaluation results?	❑ Please give them to my child at school to take home. ❑ Please mail them to the address listed above.	
When did your child last see a dentist?	❑ Less than 6 months ago ❑ Less than 2 years ago ❑ Less than 1 year ago ❑ More than 2 years ago ❑ Never	
Does your child have a regular dentist?	❑ No ❑ Yes	If yes, where?
Would you like help finding a dentist for your child?	❑ No ❑ Yes	

This program is without cost to you, but your health insurance company may be billed for services. Please complete the insurance section of this form to ensure we have the most current information. Public insurance plans generally cover the entire fee of the screening. If any costs are not covered by insurance, they will be covered by grants. No out-of-pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's two yearly dental exams.

PLEASE LIST YOUR APPLE HEALTH OR OTHER DENTAL INSURANCE INFORMATION BELOW:

DENTAL INSURANCE NAME:					
SUBSCRIBER NAME:					
RELATIONSHIP:		SUBSCRIBER GENDER:		SUBSCRIBER DOB:	/ /

BY SIGNING THIS FORM YOU AGREE TO TWO DENTAL SCREENINGS AND FLUORIDE VARNISHES.

SIGNATURE OF PARENT OR GUARDIAN	DATE

Community Based Organization
Parent/Guardian Consent Form
2020-2021 Approval

Public Health – Seattle & King County
School-Based Partnerships Program
401 5th Ave #1000
Seattle, WA 98104
206.263.8350

Neighborcare Health
School-based Health Program
1200 12th Ave S, STE 901
Seattle, WA 98144-2712
206.461.6935

Consent to Release of Education Records Under the Family Education Rights and Privacy Act (FERPA)

I consent to the release of my child's education records from the Seattle School District to the above listed agencies. I understand that education records include, but are not limited to:

1. Student name, DOB and contact information
2. Student Demographics: including Special Education status and 504 Status and race/ethnicity
3. Attendance History
4. Discipline History
5. Coursework and grades History
6. Test Scores History
7. Enrollment History
8. Assignment Grades
9. Upcoming & Missed Assignments

This release includes permission for agency staff to access my child's academic records using an automated data feed through Seattle Public Schools.

I understand that the purpose of sharing these records with the above-mentioned entities is to keep my child's school-based health center medical and/or mental health provider informed of his/her academic program and progress. In collaboration with Public Health – Seattle & King County, Neighborcare Health staff will work with my child and/or his/her school in an effort to improve my child's success at school. I acknowledge that I may revoke this consent by sending a written notification to the Seattle School District's School & Community Partnership Department, MS: 33-160 P.O. Box 34165 Seattle, WA 98124.

This Release of Information will make the above-listed educational records, which includes historical student data, available to agency staff from the date of consenting signature until December 31, 2021. I consent to Seattle School District releasing information to the above listed agencies (please print clearly):

Parent/Guardian Signature (if youth is 17 or younger): _____

Parent/Guardian Printed Name: _____

Student's Signature (if youth is 18 or older): _____

Today's Date: _____

_____ PRINT **Student's Name** (First and Last name)

_____ Student **Date of Birth**

_____ **Student **School District ID #**

_____ Student's School

***Student ID # can be found on student ASB card, report card, official school mailing, or by contacting your student's school*

neighborcare health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO EXPLAINS HOW YOU COULD GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Neighborcare Health is committed to providing you with the highest quality of care in an environment that protects your privacy and the confidentiality of your health information. To that end, this notice explains our privacy practices, as well as your rights, with regard to your health information.

Who will follow the privacy practices in this Notice

The privacy practices described in this Notice will be followed by all health care professionals, employees, trainees, students and volunteers of Neighborcare Health.

Uses and Disclosures of Health Information without Authorization

We may use or disclose your health information without your authorization to the following individuals, or for other purposes permitted or required by law, including:

Treatment

We may use or disclose your health information as necessary to provide you treatment or services. For example, we may use your health information to provide health care to you, and we may consult with other health care providers about your treatment.

Payment

We may use and disclose your health information so that the treatment you receive at Neighborcare Health may be billed and payment collected from you, an insurance company, or another third party. For example, we may share your health information to request payment and receive payment from your health insurer, and to confirm that your health insurer will pay for your treatment.

Health Care Operations

We may use or disclose your health information to carry out certain administrative, financial, legal and quality improvement activities that are necessary to run our businesses and to support our treatment and payment activities. For example, we may use your health information to evaluate the quality of services provided to you and to evaluate the performance of our staff providing care to you.

Health Information Exchange (HIE)

We may participate in certain health information exchanges whereby we may disclose your health information, as permitted by law, to other health care providers or entities for treatment, payment, or health care operations purpose. Exchange of health information can provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions.

Organized Health Care Arrangements

We may participate in joint arrangements with other health care providers or health care entities whereby we may use or disclose your health information, as permitted by law, to participate in joint activities involving treatment, review of health care decisions, quality assessment or improvement activities, or payment activities.

Neighborcare Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Neighborcare Health, OCHIN supplies information technology and related services to Neighborcare Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Neighborcare Health with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement.

Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Fundraising Activities

We may use your health information for purposes of fundraising for our organization, including releasing your information to a foundation acting on our behalf to raise money. Any communications to you about fundraising will provide you with a clear opportunity to opt out of further fundraising activities.

Additional uses and disclosures of your health information without authorization

- As required by state and federal law.
- To contact you with appointments reminders, provide test results, inform you about treatment options or advise you about other health related benefits and services.
- To third parties referred to as "business associates" that provide services on our behalf, such as billing, software maintenance and legal services.
- To disclose health care information about you to medical researchers preparing to conduct a research project.
- To prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person.
- To the military if you are a member of the armed forces and we are authorized or required to do so by law.
- To authorized federal officials for intelligence, counterintelligence or other national security activities.
- To authorized federal officials so they may conduct special investigations

or provide protection to the U.S. President or other authorized persons.

- To law enforcement officials as authorized or required by law.
- For workers' compensation or similar programs providing benefits for work-related injuries or illnesses.
- In the event of a disaster, to organizations assisting in a disaster relief effort so that your family can be notified of your condition and location.
- To coroners, medical examiners and funeral directors, as authorized or required by law as necessary for them to carry out their duties.
- If you are an organ donor, to organizations that handle such organ procurement or transplantation or to an organ bank, as necessary to help with organ procurement, transplantation or donation.
- To governmental, licensing, auditing and accrediting agencies.
- To a correctional institution as authorized or required by law if you are an inmate or under the custody of law enforcement officials.
- To a public health authority for public health activities. Public health activities include preventing or controlling disease, injury, disability, and responding to reports of abuse, neglect or domestic violence. We may disclose your health information to a person or agency required to report adverse events, product defects or problems, biologic product deviations, or for product recalls, repairs or replacements.
- To courts and attorneys when we get a court order, subpoena or other lawful instructions from those courts or public bodies or to defend ourselves against a lawsuit brought against us

Uses and Disclosures of Your Health Information with Authorization

Uses and Disclosures that Require Your Written Authorization:

- Psychotherapy Notes: We will not disclose psychotherapy notes without your written authorization unless the use and disclosure is otherwise permitted or required by law.
- Marketing: We will not engage in disclosures that constitute a sale of your health information without your written authorization. A sale of protected health information occurs when we, or someone we contract with directly or indirectly, receive payment in exchange for your protected health information.
- Minors: We will follow Washington state law when using or sharing PHI of minors. Minors who receive health care services related to HIV/AIDS; STDs, mental health treatment, alcohol/drug testing, and treatment or reproductive health may request that another person receive that information on their behalf. If the minor does not give permission in writing to anyone, we will only give information to the minor.

Other Uses and Releases

Any requests for information besides those described in this Notice will need your written permission. For example, you will need to sign a permission form before we can send PHI to your life insurance company or to your attorney. You may revoke your permission at any time by providing us with a written request.

Your Individual Rights

Right to Inspect and Copy Records

You may request to see your health records and billing records in order to inspect and/or request copies of the records. All requests to view records must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the cost of copying and sending records you request.

Right to Request Amendments

You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to an Accounting of Disclosures

You may ask, in writing, for an accounting of certain types of disclosures of your health information. The law excludes from an accounting many of the typical disclosures, such as those made to care for you, to pay for your health services, or where you provided your written authorization to the disclosure.

To make a request for an accounting see contact information below. Generally, we will respond to your request within 60 days of receiving your request unless we need additional time.

Right to Request Restrictions

You have the right to request that we place additional restrictions on our use and disclosure of your health information, including uses and disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. To request a restriction, you must tell your caregivers or contact the Privacy Office using the information listed at the end of this Notice. You may be asked to submit your request in writing. We are not required to agree to your request. If we do agree, we will notify you in writing and will honor our agreement unless the information is needed to provide you emergency treatment or we are required or permitted by law to disclose it.

If you or another family member or person on your behalf have paid your health care provider in full for a particular health care service or item and specifically request that we not disclose information about this health care item or service to your health plan for payment or healthcare operations purposes, we will agree to this request. We generally cannot restrict disclosure of information needed for health care treatment purposes.

Right to Request Confidential Communications

You may request that we contact or send PHI to you in a certain way or at a certain location, such as only at work or home, or only by mail. To request a confidential communication, please write to our Privacy Official at the address below and state how or where you wish to be contacted. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice at any time. Copies of this Notice are available throughout our locations, on our website **neighborcare.org**, or by contacting the Privacy Officer at **privacy@neighborcare.org**.

Right to Notice of Breach

You have the right to receive notifications of breaches of your health information as required by law.

Changes to this Notice

We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. If we do so, the updated Notice will be posted on our website and will be available at our locations. Upon request, we will provide any revised Notice to you.

Questions or Complaints

If you have questions about your privacy rights, or are concerned that we have violated your privacy rights, you may contact Neighborcare Health Privacy Officer at **privacy@neighborcare.org**. You also have the right to complain to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint.

Neighborcare Health
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