LSU Health Sciences Center

Notice of Privacy Practices Protected Health Information

This Notice Describes How Your Medical/Dental Information May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it CAREFULLY.

The law requires us to make sure your medical information is kept private. It also requires us to give you this notice of our legal duties and privacy practices to tell you what we can do with the medical information about you. To better understand this law, you may want to read it. It is in 45 CFR Part 164. We have the right to change this notice and our privacy practices in the future. Any changes made will apply to all of the medical information we have about you at this time. If we make a change, we will put up a notice in our building. We will also give you a copy of the new notice if you ask for it. You can also read about these changes on the computer at this website: www.lsuhsc.edu

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE USED: In general, we may use your medical information in a number of ways:

To provide patient care to you. Your medical information may be used by the doctors, nurses and other professionals who are treating you. For example, your medical information is used to help them find out your problems and to decide the best way to treat you.

Appointment Reminders. We may use your medical information to contact you to remind you of appointments, and to give you information about other treatment options, or other health – related benefits and services that may be of interest to you.

To obtain payment. Your medical information may also be used by our business office to prepare your bill and process payments from you as well as from any insurance company, government program or other person who is responsible for payment.

For our healthcare operations. Your medical information may be used to review the quality and appropriateness of the care you receive. We may also use your medical information to put together information to see how we are doing and to make improvements in the services and care we give you. In some cases we may have students, trainees, or other health care personnel, as well as some non-health care personnel, who come to our facility to learn under the guidance of faculty to practice or improve their skills.

To create de-identified databases. We may use your medical information for the purpose of removing information that tells anyone who you are, and putting it in a computer program. Your information may be completely de-identified or partially de-identified. This information is often used for research purposes. If your information is partially de-identified, it is called a "limited data set."

Fundraising. We may use your medical information to raise funds for our organization directly or to raise funds for our organization through an institutionally – related foundation or business associate.

HOW YOUR MEDICAL/DENTAL INFORMATION MAY BE DISCLOSED: In addition to using your medical information, we may disclose all or part of it to certain other people. This includes giving your information to:

You. In order to get your medical information, you will need to fill out an authorization form. You may also have to pay for the cost of some or all of the copies.

People You Ask Us To Give It To. If you tell us that you want us to give your medical information to someone, we will do so. You will need to fill out an authorization form. You may stop this authorization at any time. We are not allowed to force you to give us permission to give your medical information to anyone. We cannot refuse to treat you because you stop this authorization.

Payers. We have the right to give your medical information to insurance companies, government programs such as **Medicare and Medicaid**, and the people who process their claims as well as to others who are responsible for paying all or part of the cost of treatment provided to you. For example, we may tell your health insurance company what is wrong with you and what treatment is recommended or has been given to you.

"Business Associates." Business associates are companies or people we contract with to do certain work for us. Examples include information auditors, attorneys and specialized people providing management, analysis, utilization review or other similar services to us. Another example is giving health information to a business associate so that the business associate can create a de-identified data base. Business associates are required to agree to take reasonable steps to protect the privacy of your medical information.

Limited Data Set Recipients. If we use your information to make a "limited data set," we may give the "limited data set" that includes your information to others for the purposes of research, public health action or health care operations. The persons who receive the "limited data set" are required to agree to take reasonable steps to protect the privacy of your medical information.

The Secretary of the U.S. Department of Health and Human Services. The Secretary has the right to see your records in order to make sure we follow the law.

Public Health Authorities. We may disclose your medical information to a public health authority responsible for preventing or controlling disease, maintaining vital statistics or other public health functions. We may also give your medical information to the Food and Drug Administration in connection with FDA-regulated products.

Law Enforcement Officers. We may reveal your medical information to the police. We may also give your medical information to persons whose job is to receive reports of abuse, neglect or domestic violence. And, if we believe that releasing this information is needed to prevent a serious threat to the health or safety of a person or the public, we are permitted to reveal your medical information.

Health Oversight Agencies. We may give your medical information to agencies responsible for health oversight activities, such as investigations and audits, of the health care system or benefits programs, as allowed by law.

Courts and Administrative Agencies. We may reveal your medical information as required by a judge for a legal issue.

Coroners and Administrative Agencies. If you die, we may reveal medical information about your death to coroners, medical examiners and funeral directors, as allowed by law.

Tissue Donation and Organ Transplant Services. We may reveal your medical information to agencies that are responsible for obtaining tissue donations and obtaining and transplanting organs.

Research. We may reveal your medical information in connection with certain research activities. With your authorization, we may disclose pertinent information such as your name, social security number, study name, and dates of participation to our Accounts Payable department to issue human subjects research incentive payments.

Specialized Governmental Functions. We may disclose your medical information for certain specialized governmental functions, as allowed by law. Such functions include:

- Military and veteran activities
- National security and intelligence activities
- Proactive services to the President and others
- Medical suitability determinations; and
- Correctional institutions and other law enforcement custodial situations.

Required by law. We may also reveal your medical information in any other circumstances where the law requires us to do so.

OBJECTIONS TO USES AND DISCLOSURES:

In certain situations, you have the right to object before your medical information can be used or revealed. This does not apply if you are being treated for certain mental or behavioral problems. If you do not object after you are given the chance to do so, your medical information may be used:

Patient Directory. In most cases, this means your name; room number and general information about your condition may be given to people who ask for you by name. Also, information about your religion may be given to members of the clergy, even if they do not ask for you by name.

Family and Friends. We may disclose to your family members, other relatives and close personal friends, any medical information that they need to know if they are involved in caring for you. For example, we can tell someone who is assisting with your care that you need to take your medication or get a prescription refilled or give them information about how to care for you. We can also use your medical information to find a family member, a personal representative or another person responsible for your care and to notify them where you are, about your condition or of your death. If it is an emergency or you are not able to communicate, we may still give certain information to persons who can help with your care.

Disaster Relief. We may reveal your medical information to a public or private disaster relief organization assisting with an emergency.

YOUR RIGHTS REGARDING YOUR MEDICAL/DENTAL INFORMATION: You may also have the following right regarding your medical information:

You have the right to ask us to treat your medical information in a special way, different from what we normally do. Unless you have the right to object to the use of the information, we do not have to agree with you. If we do agree to your wishes, we have to follow your wishes until we tell you that we will no longer do so.

You have the right to tell us how you would like us to send your information to you. For example, you might want us to call you only at work or only at home. Or you may not want us to call you at all. If your request is reasonable, we must follow your request.

You have the right to look at your medical information and, if you want, to get a copy of it. We can charge you for a copy, but only a reasonable amount. Your right to look at and copy your medical records is based upon certain rules. For example, we can ask you to make your request in writing, or, if you come in person, that you do so at certain times of the day.

You have the right to ask us to change your medical information. For example, if you think we made a mistake in writing down what you said about when you began to feel bad, you can tell us. If we do not agree to change your record, we will tell you why, in writing, and give you information about your rights.

You have the right to be told to whom we have given your medical information in the six years before you ask. This does not apply to all disclosures. For example, if we gave someone your medical information so that they could treat you or pay for your care, we do not have to keep a record of that.

You have the right to get a copy of this notice at no charge.

You have the right to complain to us or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights.

If you have a complaint or concern, please call our

24 hour Hotline: (504) 568-2347

Your call will be handled by our Privacy Officer.

You may remain anonymous and all calls are kept confidential.

For further information about your rights or about the uses and disclosures of your medical information, please call

The Office of Compliance Programs at: (504) 568-2350

to speak with either our Compliance or Privacy Officer or OCP team member.

Or write to:

LSUHSC New Orleans
Office of Compliance Programs
433 Bolivar Street, Room 807
New Orleans, LA 70112

Or email:
nocompliancehotline@lsuhsc.edu

This notice is effective as of 4/13/2003
Date Last Revised 10/15/07

LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed *annually*, kept on file with the school, & is subject to inspection by the Rules Compliance Team.

Please Print

Name:_____ School:_____ Grade:_____ Date:_____

Sport(s):_____ Sex: M / F Date of Birth:_____ Age:_____ Cell Phone:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____ Home Phone:_____

Parent / Guardian:_____ Employer:_____ Work Phone:_____

FAMILY MEDICAL HISTORY: Has any member of your family under age 50 had these conditions?

Yes	No	Condition	Whom	Yes	No	Condition	Whom	Yes	No	Condition	Whom
☐	☐	Heart Attack/Disease	_____	☐	☐	Sudden Death	_____	☐	☐	Arthritis	_____
☐	☐	Stroke	_____	☐	☐	High Blood Pressure	_____	☐	☐	Kidney Disease	_____
☐	☐	Diabetes	_____	☐	☐	Sickle Cell Trait/Anemia	_____	☐	☐	Epilepsy	_____

ATHLETE'S ORTHOPAEDIC HISTORY: Has the athlete had any of the following injuries?

Yes	No	Condition	Date	Yes	No	Condition	Date	Yes	No	Condition	Date
☐	☐	Head Injury / Concussion	_____	☐	☐	Neck Injury / Stinger	_____	☐	☐	Shoulder L / R	_____
☐	☐	Elbow L / R	_____	☐	☐	Arm / Wrist / Hand L / R	_____	☐	☐	Back	_____
☐	☐	Hip L / R	_____	☐	☐	Thigh L / R	_____	☐	☐	Knee L / R	_____
☐	☐	Lower Leg L / R	_____	☐	☐	Chronic Shin Splints	_____	☐	☐	Ankle L / R	_____
☐	☐	Foot L / R	_____	☐	☐	Severe Muscle Strain	_____	☐	☐	Pinched Nerve	_____
☐	☐	Chest	_____	Previous Surgeries: _____							

ATHLETE MEDICAL HISTORY: Has the athlete had any of these conditions?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Heart Murmur / Chest Pain / Tightness	☐	☐	Asthma / Prescribed Inhaler	☐	☐	Menstrual irregularities: Last Cycle:_____
☐	☐	Seizures	☐	☐	Shortness of breath / Coughing	☐	☐	Rapid weight loss / gain
☐	☐	Kidney Disease	☐	☐	Hernia	☐	☐	Take supplements/vitamins
☐	☐	Irregular Heartbeat	☐	☐	Knocked out / Concussion	☐	☐	Heat related problems
☐	☐	Single Testicle	☐	☐	Heart Disease	☐	☐	Recent Mononucleosi
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Enlarged Spleen
☐	☐	Dizzy / Fainting	☐	☐	Liver Disease	☐	☐	Sickle Cell Trait/Anemia
☐	☐	Organ Loss (kidney, spleen, etc)	☐	☐	Tuberculosis	☐	☐	Overnight in hospital
☐	☐	Surgery	☐	☐	Prescribed EPI PEN	☐	☐	Allergies (Food, Drugs)_____
☐	☐	Medications _____						

List Dates for: Last Tetanus Shot:_____ Measles Immunization:_____ Meningitis Vaccine: _____

PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary..... **Yes** **No**
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately..... **Yes** **No**
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school..... **Yes** **No**
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its Representative(s) ..... **Yes** **No**

Date Signed by Parent **Signature of Parent** **Typed or Printed Name of Parent**

II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPATHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____ Weight _____ Blood Pressure_____ Pulse_____

GENERAL MEDICAL EXAM :

	Norm	Abnl
ENT	☐	☐
Lungs	☐	☐
Heart	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Hernia *(if Needed)*	☐	☐

COMMENTS: _____

OPTIONAL EXAMS:

VISION:

L:_____ R:_____ Corrected: _____

DENTAL:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

ORTHOPAEDIC EXAM :

	Norm	Abnl
I. Spine / Neck		
Cervical	☐	☐
Thoracic	☐	☐
Lumbar	☐	☐
II. Upper Extremity		
Shoulder	☐	☐
Elbow	☐	☐
Wrist	☐	☐
Hand / Fingers		
III. Lower Extremity		
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐

From this limited screening I see no reason why this student cannot participate in athletics.

[ ] Student is cleared

[ ] Cleared after further evaluation and treatment for:___

[ ] Not cleared for: __contact __non-contact

Printed Name of MD, DO, APRN or PA **Signature of MD, DO, APRN or PA** **Date of Medical Examination**

This physical expires one year on the last day of the month that it was signed and dated by the MD, DO, APRN or PA.

Revised 5/14

LSUHSC SCHOOL-BASED HEALTH CENTERS
LOUISIANA ENROLLMENT/CONSENT FORM

Student's Name: Last	First	Middle Initial	ID# (Office use only.)
Student's Address (include city):			Zip Code:

Student's Date of Birth:	Age:	Sex: ❑ M ❑ F	Race:	Ethnicity:
Student's Social Security Number:		School:		Student's Grade:

Preferred Language:	Student's Email:	Student's Cell Phone: ( )

Name of Mother (include maiden name) or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Emergency Contact:	Relationship:	Phone: ( )
Emergency Contact:	Relationship:	Phone: ( )

Name of Student's Primary Care Physician: Please check if student does not have a Primary Care Provider ❑	Phone: ( )
Name of Student's Dentist: Please check if student does not have a Dentist ❑	Phone: ( )

Preferred Pharmacy: (Name and location)	Names of siblings enrolled in School-Based Health Center:

Please check the type of health insurance your child has:

❑ Medicaid/Healthy Louisiana #: _____ (check one below)

❑ Aetna Better Health ❑ Amerigroup Real Solutions ❑ AmeriHealth Caritas LA

❑ LA Healthcare Connections ❑ United HealthCare Community Plan

❑ Medicaid (dental)#: _____ ❑ No insurance

Please send a copy of insurance card (front and back) to SBHC.

❑ Private/Other Insurance Co. Name: _____

Co. Address: _____

Phone #: _____ Policy #: _____ Group#: _____

Effective Date: _____

Name of policy holder: _____ Relationship to student: _____

Policy holder date of birth: _____ Policy holder Social Security #: _____

Does your insurance pay for prescriptions? ❒ No ❒ Yes

If your child does not have health insurance, would you like information on no cost health insurance? ❑ Yes ❑ No

Office use only.

Student's Name: _____ **2nd Identifier** _____

List of current medications student is on with dosage (how much) and how often:

List of all illnesses or injuries:

Is your child allergic to any food or medicine? ❑ Yes ❑ No If yes, list:

LAHIE Statement: We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.
We understand that the SBHC is funded through the Office of Public Health ("OPH") Adolescent School Health Program and, as part of such program; the SBHC is required to provide information to OPH. Therefore, we consent to the disclosure of SBHC information to OPH, or its agent, in connection with the operation, funding and ongoing monitoring of school-based health centers. We recognize that the information needed by OPH may be compiled through a HIE and consent to the disclosure of information to a HIE for such purpose.

Confidentiality: The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between LSUHSC SBHC and the student's personal physician upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that LSUHSC SBHC has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center, at 504-359-1121. My signature below constitutes my acknowledgement that I have been provided a copy of the Notice of Privacy Practices.

Louisiana Law R.S. 40:31.3 states that Health Centers in schools are prohibited from:

1. Counseling or advocating abortion or referral of any student to an organization for counseling or advocating abortion.
2. Distributing any contraceptive or abortifacient drug device, or similar product.

To report violations of the prohibitions against abortion counseling, advocacy, or referral; or distribution of contraceptives, abortifacient drugs, devices, or other similar products, contact the Adolescent School Health Program at the Office of Public Health at 504-568-3504.

_____ _____

(Patient's name – please print) Date

_____

Signature of Patient or Parent/Legal Guardian

Office use only.

Student's Name: _____ **2nd Identifier** _____

BY SIGNING THIS CONSENT, YOU ARE AGREEING TO ALLOW THE SCHOOL HEALTH CENTER TO PROVIDE THE FOLLOWING SERVICES TO YOUR CHILD:

♦Primary and preventive health care ♦comprehensive history and physical examinations ♦immunizations ♦health screenings ♦laboratory/diagnostic testing ♦acute care for minor illness and injury including medications, if indicated. ♦management of chronic diseases ♦behavioral health services ♦health education and prevention programs ♦case management ♦referral and follow-up for emergencies ♦referral to specialty care ♦dental services (where available)

I, as parent/guardian, understand that I will not be charged for any of the services provided at the school-based health center. I also understand that LSUHSC SBHC or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directly to LSUHSC SBHC.

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the school-based health center. We give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in LSUHSC School-Based Health Centers) unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. I understand that I may be asked to complete a one page form every year to update important information.

We also understand that the school-based health center is operated by **LSUHSC Department of Pediatrics, Adolescent Medicine Division** and its employees and contractors.

_____ _____

Printed Name of Parent/Legal Guardian Relationship

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Student Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

ALL SERVICES ARE SUPERVISED BY LICENSED PROFESSIONALS

July 1, 2017