School-Based Oral Health Program
Authorization Form
For the Use and Disclosure of Protected Health Information

Richard M. Daley
Mayor
City of Chicago

Child's Name :_____

Address :_____

Date of Birth :_____ School Name :_____

By signing this Authorization Form, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health to use and/or disclose my child's protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):

My child's school, the Chicago Public Schools Office of Specialized Services and the State of Illinois Healthcare and Family Service Office.

I specifically authorize the use and disclosure of the following PHI:

Information relating to PROGRAM dental services provided to my child.

This authorization is valid the date that it is signed by the child's parent or guardian until August 31, 2010.

I may revoke this authorization at any time by sending written notification to the City of Chicago, my child's school, and the Chicago Public Schools Office of Specialized Services as specified below. However, I understand that such a revocation will not have any effect on any information already used or disclosed by the City of Chicago before the City received the written notice of revocation.

Notice to the City:	Notice to the School	Notice to State of Illinois:	Notice to CPS Office of Specialized Services
City of Chicago – Department of Public Health 333 S. State, 2nd floor Chicago, Illinois 60604 Attn: Privacy Officer	Notice to the School's Principal	Healthcare and Family Service 201 South Grand Avenue East Springfield, Illinois 62763	Chicago Public Schools Office of Specialized Services – 8th Floor 125 South Street Chicago, Illinois 60603 Fax: 773-553-1881

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary and I may refuse to sign this Authorization form.

I understand that neither the dental provider nor the City of Chicago Department of Public Health may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the treatment is research-related.

I understand that I have the right to be provided with a copy of this signed authorization form.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Printed Name of Parent or Guardian Relationship to Child

Please complete the Consent Form found on the other side of this page →

SCHOOL-BASED ORAL HEALTH PROGRAM
DENTAL CONSENT FORM AND RELEASE OF LIABILITY

Dear Parent or Guardian:

As part of the "Healthy Kids, Healthy Mind" initiative, the Chicago Department of Public Health and the Chicago Public School's SCHOOL - BASED ORAL HEALTH PROGRAM (the "PROGRAM"), licensed dentists will be coming to your child's school in the near future to provide a DENTAL EXAM /SCREENING, DENTAL CLEANING, a FLUORIDE VARNISH TREATMENT and apply Dental SEALANTS (AS NEEDED) at NO COST to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child's teeth from DECAY. Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.

In consideration for your child's participation in the PROGRAM, and as evidenced by your signature below, you hereby release and hold harmless the CITY OF CHICAGO, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and THE BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to you or to your child, for any and all losses, injuries, damages to you or your child, both known and unknown, foreseen and unforeseen, arising in connection with your child's participation in the PROGRAM whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the CITY OF CHICAGO, its departments, including the Department of Public Health, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

As evidenced by your signature below, you acknowledge that a licensed practitioner providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child with your child's school, the CPS Office of Specialized Services and the Illinois Department of Healthcare and Family Service, please complete and sign the Authorization Form that appears on the back of this letter. This signed consent form is valid the date that it is signed by the child's parent or guardian until August 31, 2010.

If you would like your child to participate, please complete the below information, and return it to your child's school.

(School Name) _____ (Classroom) _____ (Student ID Number) _____ (Phone) _____

(Student Name) _____ (Date of Birth) _____ (Grade) _____ (Sex) _____

(Home Address) _____ (Apartment Number) _____ (Zip Code) _____

Hispanic (Please circle one) Yes No

Race: (Please circle one) White Black Asian / Pacific Islander American Indian/ Native Alaskan

MEDICAL INFORMATION: Has your child ever had any of the following: **YES or NO** If YES: Please circle the appropriate condition below

Diabetes Epilepsy Currently has Heart Murmur Rheumatic Fever or Rheumatic Heart Disease

Asthma Hepatitis Blood Disorder/ Disease

Is your child taking any medication? If YES, Please list medication: _____

Does your child have any Allergies? If YES, Please list Allergies: _____

Any other medical related conditions? If YES, Please list the conditions: _____

MEDICAID / ALL KIDS: Does your child participate in: (Please circle)

Free or Reduced Lunch YES / NO Medicaid / All Kids YES / NO

If YES: Please provide Medicaid / All Kids Information:

ID # _____ Case ID # _____ Eligibility Period : _____ thru _____

As the parent or guardian of the above named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM which includes a dental exam/screening, dental cleaning, a fluoride varnish treatment, the application of dental sealant(s) if appropriate, and the receiving of Quality Assurance exams. I authorize the provider dentist to use my child's or ward's Medicaid, ALL KIDS number for billing purposes only. **I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child will not receive any services under this program.**

Date: _____ Parent or guardian signature: _____

(Revised 06.15.09) Please complete the Authorization Form found on the reverse side of this page →

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