Government of the District of Columbia
Department of Health

Community Health Administration

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

Child's Name: ______________________________

Address: ______________________________

Date of Birth: ____________ **School Name:** ____________________

By signing this form, I understand that I am authorizing the dental service provider, the District of Columbia Department of Health, and the school to use and/or disclose my child's protected health information (PHI) to:

My child's school, my child's school nurse, the health or student engagement office of my child's school organization/board, the District of Columbia Department of Health, the District of Columbia Department of Health Care Finance, the District of Columbia's Medicaid Managed Care Organizations (MCOs), and any other insurance plans that my child may participate in. Additionally, information may be provided to private dentists, clinics, or hospitals if follow-up care is needed.

Information may be disclosed for the following purposes:

- To bill Medicaid or other health insurance plans.
- To assist my child in getting follow-up dental and medical care.
- To track school health service utilization and ensure compliance with current program guidelines.
- To conduct public health activities, including population health assessments and program evaluation.
- To conduct clinical and program quality assurance analyses.

This authorization is valid from the date that it is signed by the child's parent/guardian until August 31, 2016.

Notice to the District of Columbia	Notice to the School	Notice to School Board/Organization
Department of Health 899 North Capitol Street, NE, 3rd Floor Washington, DC 20002	Notice to the School's Principal	DCPS 1200 First Street, NE Washington, DC 20002 DC Public Charter School Board 3333 14th Street NW Washington, DC 20010

I understand that there is potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

This authorization is voluntary, and I may refuse to sign this Authorization Form.

I understand that neither the dental provider nor the District of Columbia 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 | Relationship to Child | Date

Government of the District of Columbia
Department of Health

Community Health Administration

Dear Parent or Guardian:

The District of Columbia Department of Health (DOH) is offering preventive dental services at your child's school. **These services will be provided at no cost to students and their families**. Licensed dentists will provide exams ("checkups") and x-rays. Other staff working with the dentists will provide dental cleanings, fluoride treatments, and sealants (as needed). Sealants protect your child's teeth from cavities when used with regular brushing and flossing. Sealants are thin, plastic coatings that are put on the tops of back teeth to "seal out" food and germs. They are put on to teeth that are not decayed. Fluoride treatments help to strengthen the teeth against decay.

Since the services we provide typically do not cause pain, our services do not include shots to numb the area. Students that need services not offered by the Program (such as fillings, tooth removal, or braces) will be referred to community dentists.

(School Name) ____________ (Teacher) ____________ (Grade) ____

(Student Name) ____________ (Date of Birth) ____________ ☐ Male ☐ Female

(Home Address) ____________ (Apt #) ____ (Zip Code) ____ (Ward of Residence) ____

Race/Ethnicity: ☐ White ☐ Black/African-American ☐ Asian ☐ Hispanic Native Hawaiian/Pacific Islander ☐ American Indian/Native Alaskan ☐ Other ____________

Parent/Guardian Name: ____________ Phone: ____________
Email: ____________ Alt. Phone: ____________

Child's Medicaid/DC Healthy Families Number____________ **Circle one of the following:** DC Healthy Families, DC Medicaid, AmeriHealth, DC MedStar, Trusted Health, Other:____________

If child has private dental insurance:
Ins. Company name (other than Medicaid)____________ Ins. Phone____________
Group #____________ Employer name____________ Co. phone____________
Name of Insured Adult____________ Birthdate of Insured Adult ____________
Member ID/Policy #____________ **Last Dental Visit:** ☐ 1-3 m ☐ 4-6 m ☐ More than 6 months

Please check each condition that applies to your child:
- ☐ Is your child under the care of a doctor? If yes, for what reason?____________
- ☐ Is your child taking any medication/drugs? If yes, what medicine is being taken? ____________
- ☐ Does your child have asthma? ☐ Does your child have an allergy to pine nuts or acrylics?
- ☐ Does your child have any serious illnesses? If yes, explain ____________
- ☐ Do you have a family dentist? If yes, please give dentist's name: ____________

As the parent/guardian of the above-named student, I consent for his/her participation in the School-Based Preventive Oral Health Program, which may include a dental examination, x-rays, a dental cleaning, fluoride gel or varnish treatment, dental sealants (if appropriate), oral health education, and Quality Assurance exams. I authorize & direct Provider to bill & collect payment from any Medicaid, private insurance, or other payer. If I have private dental insurance, I will be billed for & agree to pay any deductibles and/or co pays. Further, I agree to discharge, indemnify and hold harmless, the District of Columbia and any agency, employee, officer, agent or representative of the District of Columbia from all claims, demands, actions or judgments which I or my heirs, executors, administrators or assigns may have for any and all injuries and damages, known or unknown, caused by or arising from the activities listed above. **I understand that if I fail to sign this Dental Consent Form, my child will not receive any services offered under this program.**

Parent/Guardian Signature____________ **Date**____________

Go to Back of Page