Cleveland Clinic

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Cleveland Clinic Hospital and/or its affiliated facilities (each and all of them referred to as "CC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named below) at CC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at CC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my CC caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that CC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:

a. Subject to applicable law and the terms and conditions of any applicable contract between CC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CC for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below.

Or, b. Subject to applicable law and the Cleveland Clinic Health System Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: I have received a copy of the Cleveland Clinic Health System Patient Rights and Responsibilities brochure or the Cleveland Clinic Health System Welcome Guide.

Uses and Disclosures of Health Information: I have received Cleveland Clinic Health System's Notice of Privacy Practices. The Notice of Privacy Practices explains how Cleveland Clinic Health System may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Cleveland Clinic Health System use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by CC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CC or provide assistance to CC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that CC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who

may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to CC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by CC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge CC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Teaching Facility/Clinical Studies: CC is a teaching facility. Doctors and others in training may be involved in my (or the below-named patient's) health care. Many CC patients participate in clinical studies. I can ask my (or the below-named patient's) doctor questions about having health professionals in training involved in the care and about participating in clinical studies, and I can explain any views I have. Clinical studies at CC go through a special process required by law that reviews patient welfare and privacy. CC patients usually consent in writing to participate in clinical studies. Sometimes family members or other surrogates are asked for consent when patients are not mentally able to give their own consent. Patients are encouraged to discuss how they feel about being research participants with family members so they will know the patients' wishes if asked.

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to CC. If I choose to bring valuables to CC, I AGREE THAT CC SHALL NOT BE RESPONSIBLE FOR VALUABLES UNLESS THEY ARE DEPOSITED IN THE ADMINISTRATIVE SERVICE CENTER LOCATED IN THE HOSPITAL ADMITTING DEPARTMENT. If I do deposit valuables, CC's LIABILITY IS LIMITED to loss or damage caused by willful or wanton negligence. If I do not deposit valuables in the administrative service center, CC is not responsible for them, even if I (or the patient named below) give(s) them to other CC personnel. I also understand that CC may tell me not to use a valuable at any time. Items in CC's Lost and Found are given to charity after 30 days.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent

Signature of Patient or Responsible Party X______________________ *Date/Time* ______________

Printed Name of Patient (or Responsible Party if not the Patient) ______________________ *Responsible Party's Relationship to Patient* ______________

Phone Number(s)

Home ______________ **Cellular** ______________

-OR-

Telephone Consent

Printed Name of Individual Providing Telephone Consent ______________________ *Date/Time* ______________

Printed Name of Patient (or Responsible Party if not the Patient) ______________________ *Responsible Party's Relationship to Patient* ______________

Phone Number(s)

Home ______________ **Cellular** ______________

Cleveland Clinic Children's

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Health Information Management/Medical Record Department, Ab-7
9500 Euclid Avenue
Cleveland, OH 44195

Phone: 1- 844-203-8777
Fax: 216-587-8043

Patient: ______________________ Last 4 Digits of Patient's SSN: ______________

Date of Birth: _______/_______/_______

For the purposes of this form, "my," and "I" mean the patient listed above whose record is maintained by Cleveland Clinic.

I hereby authorize Cleveland clinic to release any and all health information that is contained in my patient records to my School District for treatment and as otherwise needed for my safety and education at the sole discretion of Cleveland Clinic. **I understand and acknowledge that this may include health information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization form will automatically expire when Cleveland Clinic is no longer providing school-based health care services to the students of my School District, when I am no longer a student of my current local School District, or when I revoke this authorization, whichever occurs first. I may revoke this authorization at any time, through written notice sent to: School Based Health Program, Community Pediatrics, Cleveland Clinic Children's, 6000 West Creek Drive, Independence, Ohio 44131. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected. The recipient of my health information may be charged for the service of releasing medical information.

If Authorization is not complete, signed, and dated, it may be returned and result in my information not being released until completed.

______________________________ _______/_______/_______

Signature of Patient/Patient's Personal Representative** Date Signed
(Student can sign if student is 18 years or older)

______________________________ ______________________________

Printed Name Relationship, if not Patient

* Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

** If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **must** accompany the request (i.e., court-appointed guardian of the person, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen.

Cleveland Clinic Children's

School-Based Health Clinic History Form

STUDENT NAME		DATE OF BIRTH	

(Please check ✓ all that apply)

ALLERGIES	
☐ YES: Please list below ☐ Food: ____ ☐ Medications: ____ ☐ Insects: ____ ☐ Seasonal: ____ ☐ Animals: ____	☐ NO KNOWN ALLERGIES

PAST MEDICAL HISTORY	
☐ Allergies ☐ Asthma ☐ Developmental ☐ Diabetes ☐ Ear Infections ☐ Gastrointestinal	☐ Heart Disease ☐ Neurological ☐ Behavioral: Please list ____ ☐ Other: Please list ____

CURRENT MEDICATIONS

Name of Medication	Dose	Amount Taken	Times per day

PREFERRED RETAIL PHARMACY

Name	Address	Phone Number

(Please check ✓ all that apply)

FAMILY HISTORY	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	*Other:* Please list
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	____
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	____
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	____
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	____
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	____
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	____
Cancer-Type?	☐	☐	☐	☐	☐	☐	☐	☐	____
Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	____
COPD	☐	☐	☐	☐	☐	☐	☐	☐	____
Depression	☐	☐	☐	☐	☐	☐	☐	☐	____
Developmental Problems	☐	☐	☐	☐	☐	☐	☐	☐	____
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	____
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	____
Gastrointestinal	☐	☐	☐	☐	☐	☐	☐	☐	____
Heart	☐	☐	☐	☐	☐	☐	☐	☐	____
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	____
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	____
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	____
Psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	____
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	____
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	____
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	

PARENT/LEGAL GUARDIAN SIGNATURE (Student can sign if student is 18 years or older)		**DATE**	

Cleveland Clinic Children's

School-Based Health Center
Student Parental/Court-Appointed Guardian Notice

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Cleveland Clinic Children's School-Based Health Center (CCCSBHC).

Student Name:														**Birth Date:**
School District:														
School:														
Grade:	**Pre K**	**K**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

I acknowledge that my son/daughter/ward named above may receive the following services at the CCCSBHC:

- Comprehensive Health Inquiry
- Physical Examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine Lab Tests
- Prescription Medications
- Care for common pediatric/adolescent physical concerns (for example, weight, acne, menstrual problems)
- Adolescent sexual health screenings and management
- Mental Health Assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Cleveland Clinic will bill your insurance company. Any co-pays will be billed. If you are uninsured, a Cleveland Clinic financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the CCCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School-Based Health Center History Form. Controlled prescriptions will need to be picked up directly from the CCCSBHC mobile unit or the nearest designated Cleveland Clinic Children's physician office.

The Cloverleaf Local School District Board of Education does not render the health care services identified above and is not responsible for damages or claims which arise solely from CCCSBHC's provision of such services.

I certify that I have read this notice and understand its contents.

Signature of Parent/Court-Appointed Guardian: ______________________________ **Dated Signed** ____________
(Student can sign if student is 18 years or older)

Relationship to Student: __________________________

Cleveland Clinic Children's

Pre-visit Questionnaire

You have enrolled your child in the School Based Health Care Program. To better serve your child we are asking you to answer the following questions and return to your child's school. This information is valuable in keeping your child healthy and learning to the best of their ability.

Patient Information

Child's Name:	
Child's Date of Birth:	
Home Address:	

Guardian Information

Primary Guardian's Name:	
Guardian Relationship to Child:	
Phone Number:	
Best time to call:	

1. Who is your child's Primary Care Provider (PCP)?
   ☐ No/PCP
   ☐ Yes/PCP – Name ______________________________
   Location ______________________________

2. Has your child had a well visit in the last year?
   Date _____ / _____ / ______ If greater than 1 year may we schedule an appointment?
   ☐ Yes ☐ No

3. Has your child visited the emergency room in the last 6 months?
   ☐ Yes ☐ No

4. Does your child have any of the following medical conditions: Asthma, Diabetes, Sickle Cell, ADHD, Anxiety, Depression, Self-harm or any other behavior concerns? Is he/she overweight or underweight?
   ☐ Yes ☐ No
   a. If yes, which condition?
   ____
   b. If yes, is your child being seen by a provider? ☐ Yes ☐ No
   If yes, who? ______________________________

5. Does your child take any daily medications?
   ☐ Yes ☐ No
   If yes, list medications:
   ____
   Is a refill needed? ☐ Yes ☐ No
   If yes, what Prescription(s)
   ____

Cleveland Clinic Children's

Pre-visit Questionnaire

6. Does your child have any other health conditions we should be aware of?
   ☐ Yes ☐ No
   If yes, which condition(s)?
   ____

7. How many days has your child missed school in the last 2 months due to illness, medication or other reason?
   ☐ None ☐ 1-2 days ☐ 3-4 days ☐ >5 days Reason:
   ____

8. How many days of work have you (parent/guardian) missed in last 2 months due to your child's illness, medication or other reason?
   ☐ None ☐ 1-2 days ☐ 3-4 days ☐ >5 days Reason:
   ____

9. Does your child have trouble learning?
   ☐ Yes ☐ No

10. Does he or she have an IEP or 504 plan at school?
    ☐ Yes ☐ No

11. Do you think your child is being bullied at school?
    ☐ Yes ☐ No

12. Does your child have a dentist?
    ☐ Yes ☐ No
    If yes, when was the child's most recent dental appointment?
    ____

13. If your child needs vaccinations at the time of his or her visit, may we complete the needed vaccinations?
    ☐ Yes ☐ No
    OK for Influenza vaccine? ☐ Yes ☐ No
    Ok for HPV vaccine? ☐ Yes ☐ No

Thank you for taking the time to answer these questions. We appreciate your input regarding your child's health and well-being. We will make every effort to help your child have a healthy and successful school year.

Cleveland Clinic Children's

School-Based Health Center
Student – Demographics

Section A: Patient Demographics

Student Name:			
Date of Birth: ______/______/______ Month Date Year		Sex: ☐ Female ☐ Male	Social Security # :
Address:			City:
State:	Zip Code:	Home Phone # :	Cell Phone #:
Preferred Language:		Do you identify as Hispanic? ☐ Yes ☐ No	
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Multiracial/Multicultural ☐ Native Hawaiian/Pacific Islander ☐ Caucasian ☐ African American ☐ Declined			
Name of Primary Care Physician:			

Section B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card:		
Date of Birth of Insurance Holder: ______/______/______ Month Date Year	Social Security # of Insurance Holder :	
Insurance Holder's Employer and Address:		
Insurance plan name:	Subscriber ID:	Group Name/Number:
Insurance Company Address:		

Section C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name:____

Phone #:______________________________________

Section D: Emergency Contact Information

Name:			
Address:			
City:	State:	Zip Code:	Relationship to patient:
Home Phone # :	Cell Phone #:		Work Phone # :

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Cleveland Clinic, we believe your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are required by law to respect your confidentiality.

This Notice describes the privacy practices of Cleveland Clinic and its affiliated facilities (CC). This Notice applies to all of the health information that identifies you and the care you receive at CC facilities. This information may consist of paper, digital or electronic records but could also include photographs, videos and other electronic transmissions or recordings that are created during your care and treatment. We are legally required to keep your health information private, to notify you of our legal responsibilities and privacy practices that relate to your health information, and to notify you if there is a breach of your unsecured health information. We are also legally required to give you this Notice and to follow the terms of the Notice currently in effect.

CLEVELAND CLINIC HEALTH SYSTEM AND AFFILIATED FACILITIES

All of our hospitals, employed physicians, doctor offices, entities, foundations, facilities, home care programs, other services, and affiliated facilities in the United States follow the terms of this Notice. These hospitals and locations are listed on our website, www.clevelandclinic.org/noticeofprivacy, or may be obtained by calling the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709).

The doctors and other caregivers at CC who are not employed by CC exchange information about you as a patient with CC employees. In connection with the health care that these health care practitioners provide to you outside of CC, they may also give you their own privacy notices that describe their office practices.

All of these hospitals, doctors, entities, foundations, facilities, and services may share your health information with each other for reasons of treatment, payment, and health care operations as described below.

HOW CC MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

When you become a patient of CC, we will use your health information within CC and disclose your health information outside CC for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

Treatment. We use your health information to provide you with health care services. We may disclose your health information to doctors, nurses, technicians, medical or nursing students, or other persons at CC who need the information to take care of you. For example, a doctor treating you for a broken leg may need to ask another doctor if you have diabetes because diabetes may slow the leg's healing process. This may involve talking to doctors and others not employed by us. We also may disclose your health information to people outside CC who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members.

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

Payment. We may use and disclose your health information so that the health care you receive can be billed and paid for by you, your insurance company, or another third party. For example, we may give information about surgery you had here to your health plan so it will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the treatment.

Health Care Operations. We may use your health information and disclose it outside CC for our health care operations. These uses and disclosures help us operate CC to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We also may combine health information about many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other persons at CC for learning and quality improvement purposes. We may remove information that identifies you so people outside CC can study your health data without knowing who you are.

Contacting You. We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. For example, we may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

Health Information Exchanges. 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 purposes. A full list of these arrangements can be found on our website, www.clevelandclinic.org/noticeofprivacy, or may be obtained by calling the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709).

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. A full list of these arrangements can be found on our website, www.clevelandclinic.org/noticeofprivacy, or may be obtained by calling the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709).

Health-Related Services. We may use and disclose health information about you to send you mailings about health-related products and services available at CC.

Philanthropic Support. We may use or disclose certain health information about you to contact you in an effort to raise funds to support CC and its operations. You have a right to choose not to receive these communications and we will tell you how to cancel them.

Patient Information Directories. Our hospitals include limited information about you in their patient directories, such as your name and possibly your location in the hospital and your general condition (for example: good, fair, serious, critical, or undetermined). We usually give this information to people who ask for you by name. We also may include your religious affiliation in the directories and give this limited information to clergy from the community. We do not release this information if you are being treated on a psychiatric or substance abuse unit. Releasing directory information about you enables your family and others (such as friends, community-based clergy, and delivery persons) to visit you in the hospital and generally know how you are doing. If you prefer that this personal information be kept confidential, you may make that request to the hospital admitting department and we will not release any of this information.

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

Medical Research. We perform medical research here. Our clinical researchers may look at your health records as part of your current care, or to prepare or perform research. They may share your health information with other CC researchers. All patient research conducted at CC goes through a special process required by law that reviews protections for patients involved in research, including privacy. We will not use your health information or disclose it outside CC for research reasons without either getting your prior written approval or determining that your privacy is protected.

Organ and Tissue Donation. We may release health information about organ, tissue, and eye donors and transplant recipients to organizations that manage organ, tissue, and eye donation and transplantation.

Legal Matters. We will disclose health information about you outside CC when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

AUTHORIZATIONS FOR OTHER USES AND DISCLOSURES

As described above, we will use your health information and disclose it outside CC for treatment, payment, health care operations, and when required or permitted by law. We will not use or disclose your health information for other reasons without your written authorization. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of health information for certain marketing purposes, and disclosures that constitute a sale of health information require your written authorization. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization in writing at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

Ohio and Florida law require that we obtain your consent for certain disclosures of health information about the following: the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition, drug or alcohol treatment that you have received as part of a drug or alcohol treatment program, or mental health services that you have received.

Florida law also requires consent for:

- Certain disclosures to family members
- Certain disclosures of health information for patient information directory purposes
- Certain disclosures of health information for payment purposes
- Certain disclosures of health information for health care operations purposes
- Certain disclosures or use of health information for solicitation or marketing purposes
- Certain disclosures of health information for research purposes
- Certain disclosures of health information relating to sexually transmitted diseases
- Certain disclosures of health information that include genetic testing or DNA analysis results

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom CC has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the CC facility that maintains the records about which you are requesting the accounting. We will not list disclosures made earlier than six (6) years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the medical records department of the CC hospital or facility that maintains the records or to the Privacy Office at DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195. We will respond to you within 60 days. We will give you the first listing within any 12-month period free of charge, but we will charge you for all other accountings requested within the same 12 months.

Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify the CC facility that maintains those records, and give the reason for your request. You must address your request to the Privacy Official of the CC hospital or facility that maintains the records you wish to amend or to the Privacy Office DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195. CC will respond to you within 60 days. We may deny your request; if we do, we will tell you why and explain your options.

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of information gathered for a legal proceeding or certain research records while the research is ongoing. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated, to the medical records department of the CC hospital or facility that maintains the records. (Requests for billing records should be sent to the billing departments.) We may charge a fee for processing your request. If CC denies your request to inspect or obtain a copy of the records, you may appeal the denial in writing to the CC Privacy Office at the following address: Privacy Office DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated, and you must identify the CC hospital or facility that maintains the information. The request should also describe the information you want restricted, say whether you want to limit the use or the disclosure of the information or both, and tell us who should not receive the restricted information. You must submit your request in writing to the medical records department of the CC hospital or facility that maintains the information you want restricted or to the Privacy Office DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195. We will tell you if we agree with your request or not. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. However, if you pay out of pocket and in full for a health care item or service, and you ask us to restrict the disclosures we make to a health plan of your health information relating solely to that item or service, we will agree to the extent that the disclosure to the health plan is for the purpose of carrying out payment or health care operations and the disclosure is not required by law.

NOTICE OF PRIVACY PRACTICES

Effective September 23, 2013

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must identify the CC hospital or facility making the confidential communications and specify how or where you wish to be contacted. You need not tell us the reason for your request, and we will not ask. You must send your written request to the medical records department of the CC hospital or facility making the confidential communications or to the Privacy Office DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195. 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. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy of this Notice at any of our facilities or by calling the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709). You also can view this Notice at our website, www.clevelandclinic.org/noticeofprivacy.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the CC Privacy Official or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with CC, you must submit your complaint in writing to the Privacy Office DD2, The Cleveland Clinic Foundation, 9500 Euclid Ave., Cleveland, Ohio 44195. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

CC may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice at each of our facilities and on our website, www.clevelandclinic.org/noticeofprivacy. The effective date of the Notice is on the first page in the top right corner.

QUESTIONS

If you have questions about this Notice, you may call the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709). A current list of CC facilities may be found on our website, www.clevelandclinic.org/noticeofprivacy, or may be obtained by calling the CC Privacy Office at 216.444.1709 (toll-free 800.223.2273, ext. 41709).

MyChart Caregiver Access ~ Child — Quick Reference Guide

Your Interactive Health Record

Parents & Court Appointed Guardians may request Caregiver Access for patients under age 18

Complete Caregiver Access for a **Parent of a Pediatric Patient** when the Parent **has a Clinic Medical Record Number (MRN)** (All other requests go through Health Data Services (HDS), see NOTE)

NOTE: Parents without an MRN & all Court Appointed Guardian requests for Pediatric Patients are processed through HDS.

- **Go to https://mychart.clevelandclinic.org/default.asp Click on MyChart for Caregivers, Select *MyChart Pediatric Caregiver Application* and print it out.** Hand the requestor the 2- page application; all of the instructions for the requestor are on the application.

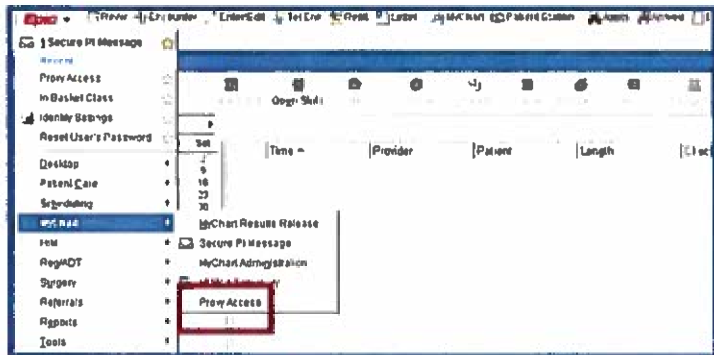
Parent Caregiver Set-Up

Grant access in the office for Parents with an MRN:

- Click **Review**; pull up the Parent that is requesting the Caregiver Access
- **Verify** Parent is **Active on MyChart**
  - Not active, Print out the parents Activation Code, tell them they will need activate their account when they get home.

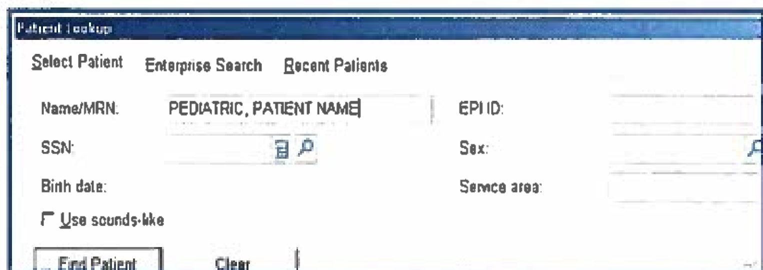
Create Proxy Access

- Click **Epic**
- Click **MyChart**
- Click **Proxy Access**



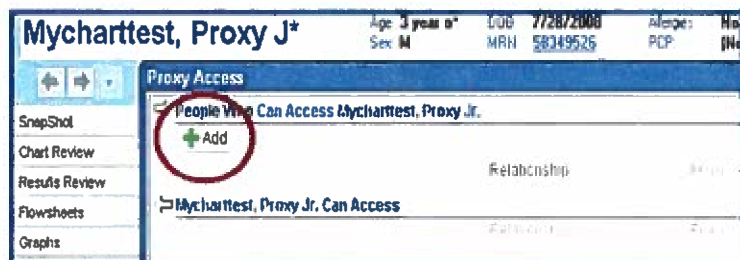
Patient Lookup Window

- Lookup the **Pediatric Patient**



Proxy Access Screen

- In Pediatric Patient record, Click on the **ADD** link



© ITD/MyChart

Cleveland Clinic

MyChart

Your Interactive Health Record

Grant Online Access Screen

- **Proxy Name:** Click the **Proxy Lookup** button to **Access the Parents record**
- **Pull** in the parent that is requesting the Caregiver access
- Relationship type select: **A Parent**
- Click **Accept**

Grant Online Access to ZZZMycharttest,Proxy Jr.

Proxy name: Proxy Lookup

Relation type

How is the proxy related to the patient?

Category Select

Search:

Title

A Parent

HDS USE ONLY Authorized Person

HDS USE ONLY Court Appointed Guardian for Adult Patient

HDS USE ONLY Court Appointed Guardian for Pediatric Patient

Accept Cancel

Profile:

What profile should the proxy have when accessing the patient's information?

Comments:

Accept Cancel

Important Steps

- Click **Enable for Proxy use** button

NOTE: If this is not clicked the parent will not have access to the Pediatric Patients' MyChart

Proxy Access

This patient is not currently active in MyChart. To allow others to access this patient's record through MyChart, enable this patient for proxy use.

Enable for Proxy Use

People Who Can Access Mycharttest, Proxy D

Add

	Relationship	From	To	Profile
Mycharttest, Maggie	Parent-Child Age Less Than 18	6/18/2012	4/6/2029	

Mycharttest, Proxy D Can Access

- **Review that the Parent is attached to the child's account** and NOT the child to the parents account by verifying that there is an expiration date listed under the "to " field
- If there isn't a "to" date listed you have reversed the proxy request. Call the help desk to revoke the relationship & start over
- **When the Pediatric Patient reaches age 18, the account is Disabled**

Proxy Access

People Who Can Access Zzzmycharttest, Proxy Jr.

Add

	Relationship	From	To	Profile
ZZZMycharttest, Mike	A Parent	10/28/2014	7/27/2026	

Zzzmycharttest, Proxy Jr. Can Access

Relationship	From	To	Profile