Parent Consent Form

Dear Parents/Guardians,

Elaine Ellis Center of Health (EECH) will be providing COVID-19 testing at **your child's school or recreational center**. If you wish for your child to participate, ***please legibly complete the following information.*** Please also attach a copy of your picture identification card to further support your consent.

Child's Name: _____

Address:_____City:_____State:_____Zip Code: _____

Date of Birth:_____Age:_____

Sex:_____(M/F) Race:_____ Ethnicity:_____

Parent's Phone Number:_____ Parent's Email Address: _____

Do we have your permission to call you? Yes __No___Text you? Yes __No___Email you? Yes___No ___

What grade is your child in?____

I give EECH permisson to send my child's COVID-19 test results to the email address or mailing address provided above.

Additional Information:

Who is your child's Primary Care Physician? _____

Is your child on any medication(s)? Yes___No___Name of medication? _____

Does your child have allergies to any medication(s)? Yes___No___Reaction: _____

Has your child had any past medical problems? Yes___No___or Surgery? Yes___No __

If yes, please explain:

Insurance Information:

Health Insurance:_____Policy Number_____

Policy Holder:_____My child does not have health insurance _____

I am the legal parent/guardian of the above named child and I give my consent for EECH to give my child a COVID-19 test at school.

Print Parent/Guardian Name: _____

Parent/Guardian Signature:_____**Date:** _____

Patient Demographic Form

Elaine Ellis Center of Health (EECH) will be providing onsite COVID-19 testing at your organization or school's campus. If you wish to participate, ***please legibly complete the following information.***

Name: _____

Address:_____City:_____State:_____Zip Code: _____

Phone Number:_____Email Address: _____

Do we have your permission to call you? Yes ___No_____

Text you? Yes _____No_____ Email you? Yes_____No _____

Date of Birth:_____ Marital Status: _____

Age:_____ Sex:_____ (M/F) Race: _____ Ethnicity: _____

Language(s) Spoken:_____

Further, if applicable, I give permission for EECH to email or mail my COVID-19 test results to the email and/or mailing addresses provided above.

Insurance Information:

Health Insurance:_____Policy Number_____

Policy Holder:_____I do not have health insurance _____

Print Name: _____

Signature:_____**Date:** _____

Elaine Ellis
CENTER OF HEALTH

AUTHORIZATION FOR ELAINE ELLIS CENTER OF HEALTH TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

I, _____ authorize The Elaine Ellis Center of Health to release and disclose the above named patient's medical information to:
Name of person or business: _____

Address: _____

For the purpose of:

- ☐ Childcare Provider/School/Summer Camp
- ☐ My personal file
- ☐ Transfer of Records
- ☐ Specialist Consultation
- ☐ Pre-operative history
- ☐ Other

Reason for Transfer: _____

To include:

- ☐ Immunization Record
- ☐ Complete Medical Record
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Mental Health Record/Notes
- ☐ Substance Abuse Record/Notes
- ☐ Notes for a specific date of service _____ *(date)*
- ☐ Notes for all dates of service _____ *(dates)*
- ☐ Other: _____

I understand that copies of records requested for my personal use given to me directly will incur a charge of 0.50 per page and a charge for postage if I request the copies be mailed to me. This fee must be paid before records will be copied. I understand that the above named patient's medical record contains confidential information. I do hereby declare that I am the patient or the patient's legal guardian and I am responsible for authorizing the release of information with regard to the above named patient. I understand that once I take possession of the medical information I assume full responsibility for safeguarding the medical information provided to me. I understand that authorizing the disclosure of this health information is voluntary; I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the privacy officer at Elaine Ellis Center of Health. I understand that I may inspect the information to be used or disclosed as provided in CFR 164,524 in accordance with the policy of Elaine Center of Health. This authorization is valid for the period of one (1) year.
Release of mental health or substance abuse records: **42 CFR part 2 prohibits unauthorized disclosure of these records.**

_____ _____
Signature of Patient /Legal Guardian Date

_____ _____
Print Name Relationship to Patient

Contact Phone Number: _____