Sign this Hawai‘i Keiki Consent Form and Your Child Can Receive Healthcare at School!

Aloha Parents/Guardians,

The Hawai‘i Keiki: Healthy & Ready to Learn Program is excited to be providing health services at your child’s school. The Hawai‘i Keiki healthcare team works together with the school to support your child’s health so they can be healthy and ready to learn.

The on-site **Hawai‘i Keiki Nurse Practitioner** (also known as an APRN) provides first aid and responds to medical emergencies on the school campus. The Nurse Practitioner also provides health education and assesses student health needs. When your child is sick or injured at school, the Nurse Practitioner is available to assess, diagnose, and treat your child with your permission. Every effort will be made to contact you to discuss the plan of care and to coordinate with you as necessary to ensure your child gets the best care possible.

With your consent, the following additional Nurse Practitioner services can be offered and provided:

- Assess, diagnose, and treat medical concerns such as earaches, sore throats, headaches, and rashes.
- Order lab tests and prescribe your child medication, when needed.
- Provide sports physicals (if you are unable to get to your child’s primary care provider).
- Coordinate with your primary care provider to ensure appropriate care for your child’s chronic conditions such as allergies, asthma, and other medical conditions.
- Care for your child’s allergies, asthma, and other medical conditions while in school.
- When needed, give your child medication, such as Tylenol, ibuprofen, or albuterol. We will attempt to contact you before giving your child any medication.
- Connect your child with a Hawai‘i Keiki Nurse Practitioner specializing in mental health for social-emotional support.

There is no cost to you for any services your child may receive whether you have insurance or not. We do request insurance information if your child does have coverage. We will bill insurance for services when appropriate. You will not receive a bill from Hawai‘i Keiki that requires a co-pay.

The Hawai‘i Keiki healthcare team does not replace the care your child gets from your primary care provider. Please review the enclosed consent form, sign it, and return it to access all of Hawai‘i Keiki’s services.

The Hawai‘i Keiki healthcare team in collaboration with the Hawai‘i State Department of Education are committed to keeping your child healthy and ready to learn. If you have any questions about the consent form or the Hawai‘i Keiki healthcare team, please contact your school’s registrar or the Hawai‘i Keiki team at hikeiki@hawaii.edu. Learn more about our program at www.nursing.hawaii.edu/hawaii-keiki.

Thank you for keeping your child healthy and learning!

HAWAI'I KEIKI
Healthy and Ready to Learn
UH Mānoa Nursing with the HI State Dept. of Education and State Public Charter School Commission

PATIENT INFORMATION & PARENTAL CONSENT FORM

Please complete the Patient Information Form on page 9 and sign the Parental Consent Form on page 10.

PART A. SCHOOL HEALTH SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Hawaii Keiki: Healthy and Ready to Learn Program ("Hawaii Keiki"), a school health program approved by the State of Hawaii Department of Education and University of Hawaii at Manoa, School of Nursing and Dental Hygiene.

I understand that confidentiality between students and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. Hawaii Keiki school health services may occur in person or via telehealth and include, but are not limited to:

1. Screening for vision (including eyeglasses), hearing, asthma, obesity, tuberculosis, and other medical conditions, first aid, and required and recommended immunizations
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
5. Mental health services, including screening, evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, & HIV, as age-appropriate.
7. Referrals for service are not provided by Hawaii Keiki.
8. Annual health questionnaire/survey.

PART B. HAWAII KEIKI AND STATE OF HAWAII DEPARTMENT OF EDUCATION FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION PARENTAL CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION UNDER FERPA

My signature on Page 10 of this document authorizes the release of my child's health records/information by the State of Hawaii Department of Education as described in the paragraph below. Such records/information may be protected from release by federal and state laws, including the Family Educational Rights and Privacy Act (FERPA), which protects the privacy of students' educational records, including health records/information in some instances.

By signing the consent on Page 10, I am authorizing my child's Hawaii Keiki-related health records and information to be released by the State of Hawaii Department of Education to the following parties for the purposes of providing medical treatment to my child, allowing providers providing services to my child to obtain payment for such services, and allowing certain other administrative activities relating to the provision of care:

- UCERA dba University Health Partners of Hawaii (the non-profit organization that provides Hawaii Keiki services in conjunction with the University of Hawaii)
- Any third-party health care providers providing services to my child under Hawaii Keiki or through referrals from Hawaii Keiki
- Any third-party payers who may pay or reimburse providers for health care treatment or services

PART C. TERMS & CONDITIONS OF SERVICE CONSENT FOR TREATMENT

Medical Services Agreement – Read Carefully Before Signing Page 10

1. **UHP:** University Clinical, Education & Research Associates dba University Health Partners of Hawaii ("UHP") is a non-profit 501(c)(3) corporation affiliated with the University of Hawaii, including its John A. Burns School of Medicine, and is comprised of its outpatient clinic locations, inpatient services, and telemedicine program.
2. **TEACHING, RESEARCH, AND HEALTHCARE INSTITUTION:** Because of its affiliation with the University of Hawaii, including its John A. Burns School of Medicine, School of Nursing and Dental Hygiene, Cancer Center, and College of Pharmacy, UHP providers perform teaching, research, and healthcare activities.
    a. **Teaching activities.** I understand that residents, interns, medical students, students of ancillary healthcare professions (for example, nursing), post-graduate fellows, and other learners and trainees may observe, examine, treat, and participate in my care at a UHP location or service under the supervision of the attending physician as part of an approved medical education program.
    b. **Research activities.** I also understand that a University of Hawaii or other institutional review board and a University of Hawaii privacy board approve human subjects research projects in accordance with state and federal law. I understand that I may be contacted and asked to participate in research studies, but I am under no obligation to participate. My decision whether to participate or not will not affect my ability to obtain medical care.
3. **CONSENT FOR TREATMENT:** I wish to receive medical care and treatment at a UHP location or service. Accordingly, I consent to the procedures that may be performed during this office visit, including emergency treatment. I authorize consent to any of the following: imaging, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical services that my physician, physician assistant, or nurse practitioner believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician. In addition, I am aware the practice of medicine and surgery is not an exact science. I acknowledge that UHP has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician or other provider any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.
4. **CONSENT FOR COMMUNICATIONS:** I understand that if I email, text, video chat, cell phone, or facsimile UHP physicians and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods; for example, unencrypted messages could be intercepted. As such, I expressly waive the UHP provider's obligation to guarantee confidentiality with respect to such correspondence using such means of communication. I acknowledge that all such communications may become part of my medical records.
5. **USE OF MEDICAL INFORMATION:** I understand that my medical information, photographs, and/or video in any form may be used for other UHP purposes, such as quality improvement, patient safety, and education.
6. **RELEASE OF MEDICAL INFORMATION TO OTHERS:** UHP will obtain my written authorization to release information about my medical treatment, except in those circumstances where UHP is permitted or required by law to release information (see UHP's **Notice of Privacy Practices in Part D on Page 4** for a description of the specific circumstances under which UHP may release this information). For example, UHP may release a copy of patient records to health care providers, health plans, governmental agencies, and workers' compensation carriers. Additional detail is provided below.
    a. **To health care providers.** I understand that UHP may share my information electronically or on paper with health care providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that UHP not use or share my information, I may submit a written request for consideration per UHP's **Notice of Privacy Practices**.
    b. **To my insurance carrier.** I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this UHP location, including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol, or other substance abuse. I understand that, according to law, I may choose

to pay out-of-pocket for certain services if I do not want my health information regarding those services to be provided to my insurance carrier. I agree to notify UHP of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for these services, my health information will be sent to my insurance carrier(s).

7. **FINANCIAL AGREEMENT:** I understand that I will receive a bill from UHP. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of UHP. UHP reserves the right to charge a Late Payment Fee and/or a Returned Check Fee.
    a. **This section is not applicable to students of the Hawaii Department of Education (DOE) and the State Public Charter School Commission (SPCSC):**
        i. **The undersigned acknowledges that if the student possesses healthcare insurance, said insurance will be invoiced for services provided.**
        ii. **The University Health Partners (UHP) will not issue invoices to students.**
        iii. **In the event of receiving an invoice or bill of services, please contact your Hawaii Keiki nurse.**
8. **MEDICARE COVERAGE:** I certify that the information I have given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare coverage effective dates and Medicare claim number to UHP. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf for UHP for any services provided by UHP.
9. **ASSIGNMENT OF BENEFITS:** I hereby authorize the assignment of the medical insurance benefits I am due to UHP for application to bills for medical services and supplies received. I further authorize UHP to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UHP and not received from my insurance carrier(s). I understand UHP is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.
10. **ACKNOWLEDGMENT OF RECEIPT:** I have read, agreed to, and received a copy of the following:
    a. **This TERMS AND CONDITIONS OF SERVICE**
    b. **NOTICE OF PRIVACY PRACTICES (in Part D on Page 4)**

PART D. NOTICE OF PRIVACY PRACTICES

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

Each time you are seen by one of UHP's providers in a hospital, faculty practice clinic, doctor's office, nursing home, or other facility, a record of your visit is made. This record contains information about your symptoms, examinations, test results, medications you take, your allergies, and the plan for your care. We refer to this information as your health or medical record. It is an essential part of the healthcare we provide for you. Your health record contains personal health information and there are state and federal laws to protect the privacy of your health information.

This health information may identify you and relate to your past, present, or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices (Notice) describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

To promote continuity and consistency of care, our providers at affiliated hospitals participate in an integrated health record system. This means that information created in the course of caring for you may reside in the integrated record and may be available to other providers participating in the integrated record system who are involved with your care. These other providers may not be UHP providers and are legally separate and responsible for their own acts.

Additionally, UHP physicians and providers use electronic health record (EHR) software that allows us to comply with Federal laws while also allowing us to gain access to shared medical records and share medical records with other providers and partners in our EHR network(s). The EHR network(s) ensure that all participating providers are adhering to strict levels of confidentiality regarding all patient records.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the privacy practices of UHP and all its facilities, and of members of UHP's organized health care arrangement, and includes the following:

- All departments, units, and clinics of UHP (as named directly below);
  - Hawaii Keiki: Healthy and Ready to Learn
  - Hyperbaric Treatment Center
  - Kuakini Medical Center
  - Native Hawaiian Health
  - Behavioral Health Clinic
  - Speech and Hearing Services
  - University of Hawaii Speech and Hearing Clinic
  - University of Hawaii Cancer Center
- All employees, providers, allied health professionals, and other authorized workforce who may need access to your PHI at our facilities;
- All residents, postgraduate fellows, medical students of the University of Hawaii John A. Burns School of Medicine, and students of other healthcare professions or educational programs at our facilities;
- All volunteers we allow to help you at our facilities;
- Any healthcare professional authorized to enter information into your medical or billing record at our facilities; and
- The University of Hawaii John A. Burns School of Medicine, or certain portions thereof, as part of an organized health care arrangement with us.

Under an organized healthcare arrangement, we may share your PHI as necessary with the members of the arrangement for treatment, payment, and healthcare operations relating to the arrangement.

OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways we may use and disclose your PHI. Not every use or disclosure in a category will be listed.

1. **Treatment.** We may use or disclose your PHI to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, and other healthcare personnel or providers to coordinate the different care you need, such as prescriptions, lab work, and X-rays. We may also permit disclosure of your electronic health record via electronic transfer to other facilities and providers for treatment purposes. We also may disclose your PHI to other people who provide services that are part of your care, such as a hospice or home care agency. We may participate in one or more Health Information Exchanges ("HIE"). Your PHI and certain basic information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment. Other providers participating in these HIEs may access this information as part of your treatment. We may also use PHI to call or send a letter to remind you about an upcoming appointment, to follow up with diagnostic test results, or to provide you with information about other treatments and care that could benefit your health.
2. **Payment.** We may use and disclose your PHI to bill and collect payment for the health care services provided to you. Your PHI may identify you, as well as your diagnoses, procedures, healthcare providers, supplies used, and other aspects of the care provided to you. We also may contact your insurance company to determine if they will pay for your medical care as part of their certification process. We may also disclose your PHI to third parties for collection of payment. For example, we may need to give your PHI to your health insurance company about a physical examination you received at UHP so your health insurance company will pay us or reimburse you for the physical examination.
3. **Health Care Operations.** We may use your PHI or disclose it to others for UHP operations. For example, UHP physicians, nurses, managers, and staff may look at your PHI to assess and evaluate the care and results in your case and others like yours. UHP is a faculty practice plan affiliated with the University of Hawaii's John A. Burns School of Medicine, so we may use or disclose your PHI in the process of educating and training students and resident physicians. Additionally, we may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.
4. **Research.** Under certain circumstances, we may use and disclose your PHI for research. In some instances, your PHI may be used or disclosed without your authorization, although only in accordance with law. Research studies are generally subject to a special review process to protect the privacy of your PHI. In some instances, we may use or allow researchers to review your PHI for the purpose of preparing a plan for a specific research project. We may use your PHI to contact you with information about a research study in which you might be interested in participating.
5. **Personal Representatives.** We may disclose your PHI to a personal representative who has authority under the law to make health care decisions on your behalf.

OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT YOU MAY AGREE OR OBJECT TO

Communication with Others Involved in Your Care. We may disclose to a family member, or other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care. The disclosure will only be done if you agree, or are silent when given the opportunity to disagree, or we believe, based on the circumstances and our professional judgment that you do not object. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. If you are incapacitated or in an emergency circumstance, we may disclose to a family member, or other relative, close personal friend, or any other person accompanying you, PHI directly relevant to that person's involvement in your care or payment related to your care.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or

object to such a disclosure whenever we practically can do so.

OUR USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

We are permitted or required to use or disclose your PHI without your authorization only in a limited number of other situations, including:

1. **Business Associates.** Some services in our organization are provided through third parties (referred to as "business associates") that provide services on our behalf, such as software maintenance and legal services. Business associates are required under federal law to implement appropriate safeguards to protect your PHI.
2. **Required by Law.** We will use and disclose your PHI when we are required to do so by federal, state, or local law, such as for the mandatory reporting of child abuse or neglect.
3. **Public Health.** We may disclose your PHI for certain public health activities. These activities generally include: prevention or control of a disease, injury, or disability; reporting of births and deaths, child abuse and neglect; reporting of reactions to medications or problems with products; notification to people about recalls of medications or products they may be using; notification to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; public health surveillance, investigations, and interventions; certain occupational health and safety evaluations with disclosure to employers; proof of student immunizations with disclosure to schools as required by law.
4. **Health Oversight.** We may disclose your PHI to a health oversight agency for certain activities authorized by law, such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
5. **Coroners, Medical Examiners, and Funeral Directors.** We may disclose your PHI to coroners, medical examiners, and funeral directors, as authorized or required by law as necessary for them to carry out their duties.
6. **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI to prevent or lessen a serious threat to the health or safety of a person or the public.
7. **Organ and Tissue Donation.** We may disclose your PHI to groups that handle organ donations and transplants.
8. **National Security, Intelligence, and Protective Services for the President and Others.** We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, as well as to others so they may provide protection to the President and other authorized persons or foreign heads of state.
9. **Military Personnel.** If you are a member of the armed forces, we may disclose your PHI as required to your military command authorities.
10. **Legal Proceedings.** We may disclose your PHI in response to a court or administrative order. We also may disclose your PHI in response to a subpoena, discovery request, or other lawful process, but only if the requesting party states that efforts have been made to tell you about the request or to obtain an order protecting the information requested.
11. **Law Enforcement.** Under certain circumstances, we may disclose your PHI for law enforcement purposes to law enforcement officials.
12. **Inmates.** If you are an inmate or in legal custody, we may disclose your PHI to a correctional institution or law enforcement official as authorized or required by law.
13. **Workers' Compensation.** We may disclose your PHI as permitted by laws relating to workers' compensation or other similar programs

ALL OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION REQUIRE YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. Most uses and disclosures of psychotherapy notes and most uses and disclosures for marketing purposes fall within this category and require your authorization before we may use or disclose your PHI for these purposes. Additionally, with certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your PHI without your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose PHI under the authorization. Disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Inspect and obtain a copy of your PHI maintained by us in health records, including billing records and any other of our records that are used by us to make decisions about you. There are a few exceptions. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to UHP at 677 Ala Moana Blvd., Ste. 1001, Honolulu, HI 96813. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs associated with your request. You may direct that the copy of your records be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. Despite your general right to access your PHI, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research study that is still in progress. Access to PHI that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. In addition, access may be denied if (i) access to the information in question is reasonably likely to endanger the life and physical safety of you or anyone else, (ii) the information makes the reference to another person and your access would reasonably be likely to cause harm to that person, or (iii) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a licensed healthcare professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing. We will make every effort to provide access to your PHI in the form or format you request if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

Request an amendment of your PHI if you feel a portion of your PHI in your health records is incorrect or incomplete. Your request must be in writing and must include the reason for your request. We may deny your request in writing if the PHI or record (i) is correct and complete, (ii) was not created by us, (iii) is not allowed to be inspected, or (iv) is not part of our records. If we deny your request, you will be notified of the reason for the denial, and you will have the right to file a written statement of disagreement. We may prepare a rebuttal to your statement of disagreement and will provide you with a copy of such rebuttal. Please contact us if you have questions about the process.

Obtain an accounting of disclosures of your PHI. However, the following disclosures will not be accounted for: (i) disclosures made more than six years before your request, (ii) disclosures made for the purpose of carrying out treatment, payment or health care operations, (iii) disclosures made to you, (iv) disclosures of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (v) disclosures for national security or intelligence purposes, (vi) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that

are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. We may charge you a reasonable fee for this accounting.

Request communication of your PHI in a certain way or at a certain location. For example, you can ask that we contact you by mail and not by telephone, or that we contact you at a specific telephone number, or that we use an alternative address for billing purposes, or that we not leave messages on certain answering machines.

Request a restriction on how we use and disclose your PHI for treatment, payment, or health care operations. However, we are not required to agree to your request except under the very limited circumstances described below. If we do agree, we will comply with your request unless the PHI is needed to provide you with emergency treatment. We may, however, also end the agreement at any time after informing you of such. We are not required to agree to your request except for a disclosure to your health plan if you pay for related items or services, out-of-pocket and in full (or in other words, you have requested that we not bill your health plan), at the time the services are provided.

Receive a paper copy of this Notice upon request. You may ask us to give you a copy of this Notice at any time. You may also obtain a copy of this Notice from our website at www.uhphawaii.org.

To exercise any of these rights, your request must be in writing and mailed to UHP at the address at the top of this page.

OUR LEGAL DUTIES REGARDING YOUR PROTECTED HEALTH INFORMATION

1. Maintain the privacy of your PHI;
2. Provide you with a notice as to our legal duties and privacy practices with respect to PHI we collect about you through this Notice;
3. Abide by the terms of the Notice currently in effect;
4. Notify you of a breach of your unsecured PHI;
5. UHP reserves the right to change this Notice of Privacy Practices and its policies and procedures for privacy practices at any time and to make the changes effective for all PHI created or received prior to the new effective date and then currently maintained by the practice location. The revised Notice will be posted on our website and in waiting rooms or patient lobbies and reasonable efforts will be made to advise you of the changes(s) in the Notice, policies, and procedures at your next service visit. You may also obtain a copy of the revised Notice upon request.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have any questions about your rights or duties or our practices and procedures regarding your PHI, please call UHP's Customer Service department at (808) 469-4900.

If you believe your privacy rights have been or are being violated, you may complain to UHP at: UHP Privacy Officer, 677 Ala Moana Blvd., Ste. 1001, Honolulu, Hawaii 96813. You may also file a complaint with the Secretary of the Department of Health and Human Services. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incident giving rise to your complaints. By law, you will not be penalized for filing a complaint.

PART E. PATIENT INFORMATION FORM

PATIENT INFORMATION	PARENT/GUARDIAN INFORMATION
Patient/Student Information:	***Primary Legal Guardian:***
Last Name: _____	Last Name: _____ First Name: _____
First Name: _____	Phone Number: _____
School Name: _____	Email: _____
Home Address: _____	Relationship to Patient: _____
_____ _____ _____	***Additional Contact:***
City State ZIP Code	Last Name: _____ First Name: _____
Date of Birth: _____ Sex/Gender: ___ M / ___ F	Phone Number: _____ Email: _____
Ethnicity: _____	Relationship to Patient: _____
___ Native Hawaiian/Pacific Islander	***Emergency Contact:***
___ Asian	*(If we are unable to reach the adults listed above)*
___ White	Last Name: _____ First Name: _____
___ Black/African American	Phone Number: _____ Email: _____
___ Prefer Not to Answer	Relationship to Patient: _____
Primary Care Provider/Pediatrician:	***Language/Translation:***
PCP/Pediatrician Name: _____	Language Spoken at Home: _____
Phone Number: _____	Do you need translation assistance? ___ Yes / ___ No
Office Address/Location: _____	___ Chuukese ___ Marshallese ___ Spanish
_____ _____ _____	___ Ilokano ___ Tagalog ___ Cantonese
City State ZIP Code	___ Other: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____

Subscribers Name: _____ Subscribers DOB: _____

Primary insurance relationship to subscriber: _____ Self _____ Other:_____

Secondary Insurance: _____ Member ID: _____

Subscribers Name: _____ Subscribers DOB: _____

Secondary insurance relationship to subscriber: _____ Self _____ Other:_____

PART F. PARENTAL CONSENT FORM

Instructions: Please sign all three (3) lines for consent to be valid.

Patient/Student Last Name: _____

Patient/Student First Name: _____

CONSENT FOR SCHOOL HEALTH SERVICES

I have read and understood the services listed in the School Health Services section in Part A on Page 1 and my signature below provides consent for my child to receive services provided by Hawaii Keiki: Healthy and Ready to Learn.

NOTE: By law, parental consent may not be required for the provision of certain health care services, including but not limited to the application of first aid treatment, the provision of services where the health of the student appears to be endangered, and certain treatment and services as set forth under Chapter 577A of the Hawaii Revised Statutes. Parental consent is not required for students who are 18 years or older or for students who are parents or legally emancipated.

Patient (18+)/Parent/Guardian Signature: _____ Sign Here **Date:** _____

Print Name: _____

CONSENT FOR RELEASE OF HEALTH RECORDS/INFORMATION

I have read and understand this consent for the release of health records and information as described in Part B on Page 1. My signature indicates my consent to the release of health records and information as specified.

Patient (18+)/Parent/Guardian Signature: _____ Sign Here **Date:** _____

Print Name: _____

CONSENT FOR TERMS AND CONDITIONS OF SERVICE

I have read the TERMS AND CONDITIONS OF SERVICE agreement in Part C on Page 2 of this packet and I am the patient or the patient's duly authorized representative. On my own behalf, or on behalf of the patient, I accept and agree to be bound by all of the terms in this agreement until I revoke my agreement, consent, or authorization in writing to UHP, or until one year since the last date of service.

☐ If the patient is a minor, check this box and indicate their age Age: ____
☐ If the patient is over 18 years of age and is incapacitated/unable to sign, check this box

Patient (18+)/Parent/Guardian Signature: _____ Sign Here **Date:** _____

Print Name: _____