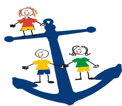

Resident's Name:_______________________ Medicaid No:______________________
Social Security No:______________________ Date of Birth:______________________
Client No:________________________

Hidle House
Emergency Shelter - Consent for Medical Treatment

The undersigned Child Protection Investigator from Department of Children and Families (DCF) or Dependency Case Manager from Big Bend Community Base Care (BBCBC) or Families First Network (FFN) has placed ____________________________________ (name of child), at Hidle House.

1. The BBCBC and/or FFN is aware that times may exist while the above named child is at Hidle House she/he may require medical treatment. I understand and agree to the following:

a. Non-emergency situations: Under its contract with BBCBC and/or FFN, Hidle House will provide medical and/or psychiatric services and treatment in non-emergency or non-life threatening situations.

b. Emergency situations: Hidle House will transport or call applicable medical and/or law enforcement personnel for necessary medical and/or psychiatric services and treatment in an emergency and life threatening situation without prior authorization from BBCBC and/or FFN. However, Hidle House will notify BBCBC and/or FFN as quickly as possible in an emergency and life-threatening situation. Licensed physicians, osteopathic physicians, emergency medical technicians and paramedics defined in Section 743.064, Florida Statutes, are authorized to provide emergency medical care or treatment without parental consent or without consent of BBCBC and/or FFN.

c. Hidle House has no authority to consent to invasive surgical procedures or the administration of psychotropic medications on behalf of the child in any situation. If invasive surgical procedures or the administration of psychotropic medications is needed, BBCBC and/or FFN is responsible for seeking proper authorization unless the medical personnel defined in Section 743.064, Florida Statutes, determine that such is necessary to provide emergency medical care or treatment.

d. Hidle House has the authority to provide the child non-prescribed, over the counter (OTC), medications on an as needed basis for the following products. I have been informed of the benefits, side effects and alternatives to medications made available.

Place initials by authorized items and write "NO" on any item not authorized.

___Acetaminophen (Tylenol) ___Ibuprofen
___Hydrocortisone Cream ___Benadryl Cream
___Antibiotic Ointment ___Hydrogen Peroxide
___Antihistamine (Equate brand) ___ Rubbing Alcohol
___Pepto Bismol/Maalox ___ cough drops
___Rid (Head Lice) ___ Other: ____________________________________
___Recreational Products (sunscreen, aloe vera, bug repellent non-DEET), etc)
___Razors

2. The child named above is **allergic to:** ____________________________________

3. Expenses for the medical care for the above named child will be determined in accordance with the contract/agreement between Hidle House and DCF, BBCBC and FFN.

Position: Child Protection Investigator Department of Children and Families/Dependency Case Manager Big Bend Community Base Care or Families First Network

Printed Name: ______________________________ Signature: _________________________________

Work phone number: _______________On-Call Number: ______________ Cell phone number: _______________

RELEASE OF INFORMATION

I authorize the reciprocal release of information between Anchorage Children's Home, ______________________
______________________________ and the health providers listed below, based upon the conditions identified on Page 1. This consent will last the duration of services or 1 year, whichever is the lesser.

I permit a copy of this authorization to be used in place of the original. I understand that if this release pertains to protected health information, it may be used and disclosed to carry out treatment, payment, or health care operations. Other allowable disclosures permitted are contained in Anchorage's Notice of Privacy Practice which I have the right to review prior to signing this consent. I also understand that the terms of this notice may change and that I will receive notice in writing either personally or by mail.

I also understand I have the right to request that Anchorage Children's Home restrict how protected health information is used or disclosed to carry out treatment, payment, or health care operations, that Anchorage is not required to agree to requested restrictions; and if the Anchorage agrees to a requested restriction, the restriction is binding. I also understand that Anchorage Children's Home is not liable for disclosures made by the entity receiving the disclosed information and that further disclosure is permissible under law.

I also understand I have the right to revoke the consent in writing, except to the extent that Anchorage Children's Home has taken action prior to my giving notice of revocation.

____ ____________________
Signature of Client Date

____ ____________________
Signature of Parent/Guardian/CPI/DCM Date

Revocation: I hereby revoke my permission to disclose information effective ____________________. I understand that this does not affect information released prior to this date.

____ ____________________
Signature of Client Date

____ ____________________
Signature of Parent/Guardian/CPI/DCM Date

IAW HIPAA 1996 – Log for Release of Information

Date	Name and Address	Description of Disclosure & Purpose