MINNEAPOLIS SCHOOL BASED CLINICS program

# Minor Consent and Clinic Registration

Minneapolis Health

## Student Information

***Last name:** _____ ***First name:** _____

**Preferred name:** _____ ***Student ID:** _____

***Birth date:** _____ ***Social Security Number:** _____

***Sex at birth:** ❑ Female ❑ Male ❑ Intersex ***Gender identity:** ❑ Female ❑ Male ❑ Gender non-binary

***Preferred pronouns:** ❑ She/her ❑ He/Him ❑ They/them ❑ Other:_____

***Address:** _____ ***City:** _____ **Zip:** _____

***Language(s) spoken at home:** _____

***Race(s):** ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic/Latino ❑ Multi-racial ❑ White

***Ethnicity:** ❑ Hispanic/Latino ❑ Hmong ❑ Non-Hispanic/Latino ❑ Somali ❑ Other African ❑ Other:_____

**Student phone:** _____ ❑ Cell ❑ Other Okay to text? ❑ Yes ❑ No

**Student email:** _____

**If you go to another clinic, please list it:** _____

***School:** ❑ Camden ❑ Edison ❑ FAIR ❑ Longfellow ❑ Roosevelt
❑ South ❑ Southwest ❑ Washburn ❑ Wellstone ❑ Other: _____

**How did you hear about the School Based Clinics?**
❑ Classroom Presentation ❑ Coach ❑ Friend ❑ Parent ❑ School Nurse
❑ SBC Website ❑ Teacher/School Staff ❑ Social Media ❑ Other:_____

## Insurance

Services are provided at no cost to families whether or not a student has insurance. Insurance is billed whenever possible to help cover the costs of care.

*Please choose one*

❑ **I don't know my insurance info** ❑ **I don't think I have insurance**

**Medical Assistance/Public Health Insurance**

❑ State of Minnesota ❑ Blue Cross ❑ UCare ❑ MHP ❑ Health Partners

Group Number: _____ Policy Number: _____

**Private Health Insurance**

❑ BlueCross/BlueShield ❑ Health Partners ❑ Medica ❑ Portico ❑ Preferred One ❑ UCare
❑ Other: _____

Group Number: _____ Policy Number: _____
Policy Holder Name: _____

**If you have private insurance, your parent/guardian may see the charges. Is it okay to bill this insurance?**
❑ Yes ❑ No

***Signature required on back*** ↘

# Minor Consent and Clinic Registration

Minnesota law (statute 144.341-347) allows people under the age of 18 to consent to and access pregnancy services/birth control and testing and treatment for sexually transmitted infections without parental consent. Statute 144.3431 allows minor 16 years old or older to consent for mental health services.

*Please initial after each statement to show you have read and understand each statement*

| Required for all clinic visits | Initial |
|---|---|
| 1. I am able to understand health information. | |
| 2. I am giving permission to potentially receive reproductive healthcare. | |
| 3. I have been or will be given an opportunity to discuss my questions and concerns. | |

**By signing this form you agree that:**

- The statements above are true and represent my current situation. The information discussed today included, but was not limited to, the statements above. I request and consent to reproductive health services.
- If I have private health insurance or Medical Assistance/Public Health Insurance, I also authorize the clinic to release information about my health to insurer for the purpose of billing.
- Your consent is good until you turn 18 or no longer use the School Based Clinic.

_____

Student Name *please print*

_____ _____

Student Signature Date

**Please submit this completed form to the school based clinic in your school**.

For more information, please visit www.minneapolismn.gov/sbc or contact the program manager at 612-673-5305 or your school based clinic.

MINNEAPOLIS SCHOOL BASED CLINICS program

# Data Privacy Acknowledgement

*a program of the* Minneapolis Health Department

**Why are we giving you this form to sign?**

To let you know how private health information about you may be used, shared and how you can get access to this information. As we care for your health, we learn about you. Some of what we learn becomes part of your medical record and billing records. To protect your privacy the School Based Clinic follows state and federal laws. The Notice of Privacy Practices provides detail about these rules.

**Who has access to the information you supply?**

1. Upon request, YOU may generally review any information the Clinic collects concerning your care.
2. Upon request, YOUR PARENTS may generally review information the School Based Clinic collects concerning your care, except for the following:
    a. If your clinic visit was related to pregnancy and conditions associated with pregnancy, sexually transmitted diseases, family planning, alcohol and/or drug abuse
    b. You have the right to request that parental access to all of your clinic health information be denied. If you do not want your parents to have access to any of your clinic health information, you must make that request in writing explaining the reasons you do not want your parents to have access to your health information and sign the request. The Clinic will honor your request to deny parental access if your health care provider determines that it would be in your best interests to do so. You can request a "Deny Parental Access Form" from Clinic staff to make your request.
3. School-Based Clinic staff and contractors whose work assignment requires it.
4. Other health care professionals when necessary for providing care for you.
5. Child Protection and/or law enforcement agencies on matters relating to suspected child abuse/neglect.
6. State, Federal, and local agencies or health departments may be provided summary information for statistical purposes with all identifying information removed.
7. We may release your information to protect the health or safety of you or others.
8. Our attorney and our attorney's staff if necessary.
9. Others as described in our Notice of Privacy Practice, including when we are required by law, including officials with a valid subpoena, warrant, or court order.

Information will not be given to any other agency or individual without your (or, when appropriate, your parent's) written consent unless authorized by state or federal law.

The School Based Clinic Medical Records are kept separate from any school records. When you leave high school, your records will be securely stored as required by law.

**What are your rights when supplying information?**

You have the right to refuse to supply the information we request. However, refusal to supply medical history and other information limits our ability to provide quality health care and may result in ineffective treatment or no treatment at all.

**Acknowledgement of Receipt of the Notice of Privacy Practices**

Our Notice of Privacy Practices provides information of how our clinic may use or share private health information about you for treatment, payment and clinic operations. A paper copy is available at each School Based Clinic or can be found on our web site: https://www.minneapolismn.gov/sbc.

I acknowledge that I have received a copy of the School Based Clinic Notice of Privacy Practices.

_____

Student Name *please print*

_____ _____

Student Signature Date