

**BURLINGTON SCHOOL-BASED HEALTH CENTER**  
**INFORMATION RELEASE AND PAYMENT ASSIGNMENT FORM**  
*Must be completed in advance of participation in a Burlington School-Based Health Center.*

I understand that am providing this authorization for the purposes of obtaining professional primary health care and behavioral health care services for my children and to assign any payments for these services to which I might be entitled to the "Service Providers" involved in the School Based Health Center(s) ("Center"). I further understand that this authorization only covers services provided at the school sites and it does not cover services provided through referrals from the Center.

**Acknowledgment of Release of Information**

The School-Based Health Centers work with a team of Service Providers from local health care and social agencies to assist your children. To allow the team to work together effectively, we ask parents to authorize Center staff, the individual Service Providers and their supervisors to share information only when necessary. I authorize the Center staff, appropriate School District personnel, and the individual Service Providers and their supervisors (please initial the applicable entities) to discuss appropriate information pertaining to my child only when needed:

- Burlington School District social workers, school health personnel, counselors and principal.
  - The Baird Center for Families/Howard Center for Human Services.
  - Community Health Center of Burlington OR Fletcher Allen Health Care – University Pediatrics.
- (By not checking one of the above, I understand I am limiting the services available to my child.)

I authorize the Service Provider for primary care at the Center to see my child:

- Whenever the child needs medical care
- Only when I have given specific oral or written permission (except in the case of a medical emergency)
- Only when I am present (except in the case of a medical emergency)

I also authorize the Centers and Service Providers to communicate with my child's regular primary care provider.

**Assignment of Benefits**

I hereby assign to the Centers and the Service Providers any and all payments to which I am entitled under any health insurance policy for health care and behavioral health care services rendered to my children by the Centers and the Service Providers as long as the charges for services by the Centers and the Service Providers do not exceed the Service Provider's regular charges. I further authorize the Centers and the Service Providers to bill and receive payment directly from my insurance carrier(s) for those services that the Center or the Service Providers delivered and for which I may be entitled to insurance coverage. I also authorize the Centers and the Service Providers to give to my health insurance carrier(s) any information necessary for billing purposes for such periods of time as my children have received or are receiving primary health care or behavioral health care services until such time as my children are discharged from care.

I understand the Centers and the Service Providers will protect the privacy of my children's health and educational records to the extent required by federal and state law. I understand that I may revoke this authorization at anytime if I make a written statement revoking the authorization and deliver it to the Burlington School District, Grant Programs, 150 Colchester Avenue, Burlington, VT 05401.

I understand that as a condition of this authorization, if the Center or the Service Providers judge my child to be a serious danger to him/herself or others, then the Center and/or the Service Providers reserve the right to inform a physician, others who may be at risk, designated emergency contacts and appropriate emergency services.

I \_\_\_\_\_ have read the above material and understand its meaning. My signature below is an acknowledgement that I have reviewed this form, understand the information and consent to all of the actions described above. My signature also attests to the accuracy of the information provided on both sides of this form.

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

## Burlington School-Based Health Centers – Registration Information

Please complete to participate in the Burlington School-Based Health Center. All information is confidential.

Name of parent/guardian \_\_\_\_\_ Telephone number \_\_\_\_\_

Social Security number of parent/guardian \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Work phone number: \_\_\_\_\_

Emergency contact \_\_\_\_\_ Telephone number: \_\_\_\_\_

Child's name			
Date of birth			
Social Security number			
Medicaid number			
Gender			
Race (circle one) <i>Optional: Needed by Community Health Center for its funding.</i>	Black/African-American Asian Caucasian/white Hispanic/Latino American Indian Pacific Islander Other	Black/African-American Asian Caucasian/white Hispanic/Latino American Indian Pacific Islander Other	Black/African-American Asian Caucasian/white Hispanic/Latino American Indian Pacific Islander Other
<b>Medical information:</b> Please indicate yes or no and provide as much detail as possible.			
Allergies, if yes to what?			
Asthma			
Seizure or other disorder			
Other medical issues			

Name of primary care physician \_\_\_\_\_ Office \_\_\_\_\_

Name of insurer (check one) Please attach a copy of the insurance card.

\_\_\_\_\_ Medicaid

\_\_\_\_\_ Dr. Dynosaur

\_\_\_\_\_ Blue Cross-Blue Shield of Vermont

\_\_\_\_\_ Cigna

\_\_\_\_\_ MVP

\_\_\_\_\_ Other: \_\_\_\_\_

Insurance policy number \_\_\_\_\_

### Income information

(Optional. Community Health Center needs this income information for future funding requirements.)

Annual household income \_\_\_\_\_ Family size \_\_\_\_\_