



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

Date: \_\_\_\_\_

Returning Student:   
K-8  7-12  PH

**Student Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*First Middle Last*

Sex: Male  Female

Social Security Number: \_\_\_\_\_

Race: African – American  Hispanic  Asian/Pacific Islander   
Caucasian  Multi-Racial  Native American  Other

Primary Language Spoken in Home: \_\_\_\_\_

Street Address: \_\_\_\_\_  
*Street Apartment City/State Zip*

\* Transportation is based on this address\*

Grade Level: \_\_\_\_\_  
*Entering this School Year*

Home School District: \_\_\_\_\_

Last Two Schools Attended: \_\_\_\_\_

**Student Lives With:**

**Student's Legal Guardian:**

\_\_\_\_\_  
*Name Relationship*

\_\_\_\_\_  
*Name Relationship*

\_\_\_\_\_  
*Phone Number Address*

\_\_\_\_\_  
*Phone Number Address*



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

**Date:** \_\_\_\_\_

**Emergency Contacts:**

List below the names, relationship to the child and phone numbers of people we can call in the event of an emergency, whether health related or behavioral. Please list contacts in the order you would like them to be called. If we are unable to reach someone when an emergency arises, our School Resource Officer (SRO) will either take your student to Children Hospital Medical Center or 2020. Please be aware that if your student becomes ill or is injured and must leave the program, he or she may be released to anyone on the list below.

**Student's Name:** \_\_\_\_\_

\*A Minimum Of Three Contacts Must Be Listed\*

**Contact:**

_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

Date: \_\_\_\_\_

**Professional Contacts:**

List below the names and contact information for all professional providers including: JFS Worker, therapist, case managers, probation officers and other providers.

**Student's Name:** \_\_\_\_\_

\*All External Providers Must Be Listed\*

_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>
_____ <i>Name</i>	_____ <i>Relationship</i>	_____ <i>Phone Number</i>



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

Date: \_\_\_\_\_

**Notification and Consent For Follow-Up Survey:**

**NOTIFICATION AND CONSENT  
FOLLOW-UP SURVEY**

I agree to be contacted after services have ended for the purposes of gathering transitional information. This information will be gathered by telephone with either you or your school district representative at 30 days, 180 days, and one year following discharge from Early Childhood Programs and Education Programs. The purpose of this information is to begin to develop some benchmarks for measuring the effectiveness of Early Childhood and Education Programs.

By signing below, I acknowledge the above information has been discussed with me and I understand the process. I also understand that I may choose at any time, not to participate in these surveys.

\_\_\_\_\_  
*Signature of Legal Guardian*

\_\_\_\_\_  
*Date Signed*

\_\_\_\_\_  
*Client Signature (when applicable)*

\_\_\_\_\_  
*Date Signed*

\_\_\_\_\_  
*Program Enrolled*



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

Date: \_\_\_\_\_

**Authorization for Release of Information:**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN (optional): \_\_\_\_\_

I, \_\_\_\_\_  
(Full name of client or legal guardian)

Authorize \_\_\_\_\_  
(Full name of individual, class of individuals or organization that is to make the decision)

\_\_\_\_\_  
(Mailing address and/or phone number if applicable)

release to **OR**  exchange with the following individual or organization:

The Children's Home Of Cincinnati

(Full name or title of the person, class of individual(s) or organization to which disclosure is to be made)

5050 Madison Road Cincinnati, Ohio 45227

(Mailing address and/or phone number if applicable)

to  disclose or  re-disclose the following information:

(Check those that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Client assessment/evaluations | <input type="checkbox"/> Treatment/service history | <input type="checkbox"/> Individual client plans   |
| <input type="checkbox"/> IEP/school records/reports    | <input type="checkbox"/> Psychological evaluations | <input type="checkbox"/> Laboratory results        |
| <input type="checkbox"/> Social history                | <input type="checkbox"/> Treatment progress notes  | <input type="checkbox"/> Current treatment records |
| <input type="checkbox"/> History and physical exam     | <input type="checkbox"/> Alcohol/drug diagnosis    | <input type="checkbox"/> Drug screen results       |
| <input type="checkbox"/> Current medications           | <input type="checkbox"/> HIV test results          | <input type="checkbox"/> AIDS diagnosis            |
| <input type="checkbox"/> Other (specify: _____)        |  |  |



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

**Amount of information to be disclosed:**

- information covering the previous three months
- information covering the most recent admission
- information from beginning to present
- other amount of information (specify) \_\_\_\_\_

**for the following purpose(s);** (check those items that apply)

- report client progress
- to obtain collateral information in treatment of this client
- verify client attendance at activities
- determine eligibility for social services
- other \_\_\_\_\_

**Re-disclosure statement**

I understand that the information in my clinical record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This authorization of release of information is subject to revocation at any time except to the extent that the program has already released information in response to this authorization or otherwise prohibited by law. I understand that if I revoke this authorization I must do so in writing. I also understand that the revocation will not apply to my insurance company when law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. If I have any questions about disclosure of my clinical record; I can contact \_\_\_\_\_ at \_\_\_\_\_.

**This authorization will terminate upon the earlier of:**

(For clients **not** in the criminal justice system)

- 90 days after the date of signed authorization (ODMH funded sites, except for long-term programs)
- 180 days after the date of signed authorization (Long-term mental health; simultaneous mental health & criminal justice; substance abuse)

**OR**

- the date of the client's discharge from the agency

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

For clients in the criminal justice system who have agreed to participate in drug treatment or rehabilitation programs as a condition of probation, parole or rehabilitation:

\_\_\_\_ A. Consent to release the above information to criminal justice referral sources is not revocable until the final disposition of the action in connection with which the client was referred. It shall expire when there is a substantial change in the client's status with the referral resource, for example, case termination, revocation of probation, parole, release, etc., whichever is later.

\_\_\_\_ B. If the person or agency to receive the information indicated above is not the client's referral source, this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance of it. Otherwise, this consent to disclose information shall expire in 90 days, or upon the client's discharge from the program, whichever is earlier.

\_\_\_\_ **Witness Initials**

**For clients in substance abuse and mental health programs:**

\_\_\_\_ Consent to obtain/release information concerning persons in treatment for substance abuse, even if those problems are not the primary reason for treatment, shall adhere to the Federal rules, which restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. ***Federal rules prohibit further disclosure of this information unless this is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.*** This consent shall expire in 90 days unless other date is entered by the client here \_\_\_\_\_ at the time this authorization is signed. This consent may be revoked at any time.



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

\_\_\_\_\_/\_\_\_\_\_  
(Signature of Client or Legal representative/Date) (Signature of Parent/Guardian/ Date)

\_\_\_\_\_/\_\_\_\_\_  
(Relationship to Client – ie., Parent, Legal Guardian) (Signature of Witness/ Date)

Client Name: \_\_\_\_\_ Client # \_\_\_\_\_

**Withdrawal/Revocation of Consent**

\_\_\_\_\_  
*Date Consent Withdrawn*      \_\_\_\_\_ *Signature of Legal Guardian*      *or*      \_\_\_\_\_ *Signature of Staff*

- Client was notified that according to HIPAA regulations we are required to provide them a copy of this release form. **Client chose not to receive a copy.**
- Client was notified that according to HIPAA regulations we are required to provide them a copy of this release form. **Client received a copy.**



The Children's Home of Cincinnati  
Education Program  
2010 - 2011

Date: \_\_\_\_\_

**Emergency Medical Authorization:**

**Purpose** - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (other parent/guardian) at \_\_\_\_\_ (phone number), have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_, (preferred physician) or Dr. \_\_\_\_\_ (preferred dentist), or in the event the designated preferred practitioner is not available by another licensed physician or dentist and (2) the transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**Please list all medical conditions including diagnosis/disabilities and all allergies:**

Please check below all that apply:

- |                     |                          |  |                          |                                     |                          |
|---------------------|--------------------------|--|--------------------------|-------------------------------------|--------------------------|
| Alcohol Abuse       | <input type="checkbox"/> | Liver Disorders                            | <input type="checkbox"/> | Emotional Problems & Mental Illness | <input type="checkbox"/> |
| Heart Trouble       | <input type="checkbox"/> | Cancer                                     | <input type="checkbox"/> | Sight, hearing, speech Impairment   | <input type="checkbox"/> |
| Allergies           | <input type="checkbox"/> | Meningitis                                 | <input type="checkbox"/> | Encephalitis                        | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | Cystic Fibrosis                            | <input type="checkbox"/> | Tuberculosis                        | <input type="checkbox"/> |
| Anemia              | <input type="checkbox"/> | Miscarriages, stillbirths, neonatal deaths | <input type="checkbox"/> | Epilepsy/Seizures                   | <input type="checkbox"/> |
| Hormonal Disorder   | <input type="checkbox"/> | Dental Problems                            | <input type="checkbox"/> | Ulcers/Stomach Issues               | <input type="checkbox"/> |
| Arthritis           | <input type="checkbox"/> | Developmental Delay                        | <input type="checkbox"/> | Other:                              | <input type="checkbox"/> |
| Kidney Problems     | <input type="checkbox"/> | Diabetes                                   | <input type="checkbox"/> |                                     |                          |
| Asthma              | <input type="checkbox"/> | Paralysis                                  | <input type="checkbox"/> |                                     |                          |
| Learning Disability | <input type="checkbox"/> | Drug Abuse                                 | <input type="checkbox"/> |                                     |                          |
| Birth Defects       | <input type="checkbox"/> | Rheumatic Fever                            | <input type="checkbox"/> |                                     |                          |
| Leukemia            | <input type="checkbox"/> |  |                          |                                     |                          |
| Bowel Problems      | <input type="checkbox"/> |  |                          |                                     |                          |

Any medical problems listed above will be shared with the staff involved with your child's program. If you do not want this information shared, you are required to state this in writing and submit your statement to the school. Please remember that no medication prescribed or over-the-counter will be administered to your child without the written consent of the parent / guardian AND physician.

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**PARENTAL CONSENT FOR PHYSICAL HOLD:**

I authorize The Children's Home of Cincinnati to provide for the day-to-day safety and security of \_\_\_\_\_ including the use of physical hold per The Children's Home of Cincinnati policies and procedures.

*Students Name*

**Therapeutic Crisis Intervention (TCI)**

The skills, knowledge and professional judgment of our staff in reacting to crises are critical in helping our students learn constructive and adaptive ways to deal with frustration, failure, anger, rejection, hurt, etc. The ability of our entire staff to respond effectively to children in crisis is critical in establishing not only a safe environment but also one that promotes growth and development. The purpose of TCI is to provide a crisis prevention and management system, which will do the following:

- Preventing crises from occurring,
- De-escalating potential crises,
- Effectively managing acute crisis phases,
- Reducing potential and actual injury to students and staff, and
- Learning constructive ways to handle stressful situations.

TCI is a model for crisis prevention and intervention that gives staff:

- The skills, knowledge, and attitudes to help children and youth when they are at their most destructive;
- An appreciation of the influence adults have while they are responsible for the care and treatment of troubled children and youth in crisis situations; and
- The sensitivity to respond to both the feelings and behavior of an upset youth in crisis.

\_\_\_\_\_  
*Signature of Legal Guardian/Parent*

\_\_\_\_\_  
*Relationship to Client*

\_\_\_\_\_  
*Date Signed*

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Authorization to Administer Medication:**

The policy of The Children's Home of Cincinnati requires consent from the parent/legal guardian and an order from the physician before **ANY** medication can be given to a child by our nursing staff. The following information is necessary to comply with this policy.

**ALL ITEMS MUST BE COMPLETED IN FULL.**

**MEDICATIONS MUST BE BROUGHT IN BY GUARDIAN. NO STUDENT MAY BRING THEM IN.**

For assistance please call 513.272.2800 ext. 4106 or 4119. Information can be faxed to 513.631.7484. Lower School students call 513.272.2800 ext. 3237

CHILD'S NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

\*\*\*\*\*

**TO BE COMPLETED BY PHYSICIAN ONLY:**

The above child is under my care for (diagnosis \_\_\_\_\_), and should receive \_\_\_\_\_ at the following times:

*Medication* \_\_\_\_\_ *Dosage and Route* \_\_\_\_\_

Specific instructions for administration : \_\_\_\_\_  
\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_  
\_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date of this Request: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature                      Date                      Physician's Number

Please complete order for self-administration: yes no

Assistance for self-administration is as follows: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature                      Date                      Physician's Number

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

**ORDER TO SELF-ADMINISTER MEDICATION:**

As a physician I agree with the treatment team at The Children's Home of Cincinnati, Ohio in the assessment that this client is able to self-administer medication.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Number

\*\*\*\*\*  
THE MEDICINE MUST BE IN A CLEARLY MARKED CONTAINER FROM THE PHARMACIST. THE LABEL MUST SHOW THE CHILD'S NAME, DOSAGE, DIRECTIONS, THE DOCTOR'S NAME, RX NUMBER AND HAVE THE CURRENT DATE ON THE PHARMACY BOTTLE. (Over the counter medication must be in the package in which it was purchased.)  
**MEDICATIONS MUST BE BROUGHT IN BY GUARDIAN. NO STUDENT MAY BRING THEM IN.**

\*\*\*\*\*  
**TO BE COMPLETED BY PARENT/GUARDIAN:**

I give my permission for the staff of The Children's Home to administer the medication as prescribed above, and further agree to the following:

1. Submit to The Children's Home of Cincinnati, Ohio a revised statement signed by the physician who prescribed the above medication when any change in the original physician's statement occurs;
2. Submit to The Children's Home of Cincinnati, Ohio a written statement when medication given on a daily basis has been discontinued and why; and,
3. Release The Children's Home of Cincinnati, Ohio and their designated personnel from any liability concerning the administration or non-administration of the prescribed medication to the child.

\_\_\_\_\_  
Parent/Guardian Signature:

\_\_\_\_\_  
Date:

THIS PERMISSION IS NO LONGER VALID AT THE END OF THE SCHOOL YEAR OR END OF PROGRAM.

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Consent for Photographic, Cinematic and/or Voice Reproduction:**

This release is based on the following conditions:

- Materials produced become the property of The Children's Home of Cincinnati
- Release is given without promise of compensation
- Release is effective until terminated by a written retraction from the person granting this authorization
- The parent or legal guardian and child/client release to The Children's Home of Cincinnati any right, title, and/or interest of any kind they may have in the records produced.

**Release for Photographic, Cinematic, and/or Voice Reproduction for publicity purposes:**

I hereby grant The Children's Home of Cincinnati the right and authority to photograph, film, and/or vocally record:

---

(Please print) Child/Client Name

Age

The materials produced may be used for promotional or publicity purposes, and may be used in mass media publications, on the organization's websites and social media sites, televised, or used in film presentations. Media resources include, but are not limited to, newsletters, annual reports, brochures, professional publications, and special event/promotional materials. Actual names of clients and families will not be used. This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent further use of recorded materials.

\_\_\_\_\_  
Signed (Parent/Legal Guardian)

\_\_\_\_\_  
Witness (for authorization by phone)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Permission to use Public Transportation: (UPPER SCHOOL ONLY)**

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_

- Give  
 Do Not Give

permission for my child to take public transportation to and from school. I understand that bus/cab fare is the responsibility of the parent/guardian and the school will not provide this for my child.

\_\_\_\_\_  
*Signed (Parent/Legal Guardian)*

\_\_\_\_\_  
*Date*

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Handbook(s) Acceptance Forms:**

**Parent/Guardian Handbook Acceptance Form**

I, \_\_\_\_\_, Parent/Guardian of \_\_\_\_\_

Have read and agree to abide by the information within the school handbook. I have read and understand these Client's Rights and Grievance Procedures as outlined in the school handbook.

\_\_\_\_\_  
*Student Name*

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

---

**Student Handbook Acceptance Form**

I, \_\_\_\_\_, have read and agree to abide by the information within the school handbook.

\_\_\_\_\_  
*Student Name*

\_\_\_\_\_  
*Date*

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Mental Health Referral Form:**

CONSENT FROM GUARDIAN FOR COUNSELING: YES:  NO:

STUDENT'S NAME: \_\_\_\_\_ Student's DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Student's Social Security Number: \_\_\_\_\_

School: \_\_\_\_\_

School Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Student's Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Student's Phone Number: \_\_\_\_\_ Name of Parent/Legal Guardian: \_\_\_\_\_

Student Lives with: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

**REASON FOR REFERRAL:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONTACT INFORMATION:      PHONE: 272-2800      FAX: 631-7484

PRIMARY CONTACTS:      Lorraine Long, Intake Specialist x 4301  
Matt Robinson, Intake Specialist x 4118  
Jennifer Boggs, Program Support and Intake Supervisor x 4322

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

Date: \_\_\_\_\_

**Notice of Privacy Practices and Acknowledgement:**

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

If you have any questions, please contact our Privacy Officer, whose name and number are at the bottom of this notice.

**Who will follow this notice?**

The Children's Home of Cincinnati provides health care to our clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care, mental health or social service professional who provides services to you at any of our locations.
- All departments and units of our organization, including: the Mental Health Services Department, Adoption Services Department, and Every Child Succeeds Program and all locations of these departments and programs.
- All employed associates, staff or volunteers of the Mental Health Services Department, Adoption Services Department and the Every Child Succeeds Program of the Early Childhood Services Department.
- Any business associate or partner of The Children's Home of Cincinnati with whom we share health information.

**Our pledge to you.**

We understand that health care information about you is personal. We are committed to protecting health care information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- keep health care information about you private.
- give you this notice of our legal duties and privacy practices with respect to health care information about you.
- follow the terms of the notice that is currently in effect.

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

**Changes to this Notice.**

We may change our policies at any time. Changes will apply to health care information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at [www.thechildrenshomecinti.org](http://www.thechildrenshomecinti.org)

You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

**How we may use and disclose health care information about you.**

■ We may use and disclose health care information about you for **treatment** (such as sending health care information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicaid); and **to support our health care operations** (such as comparing client data to improve treatment methods.)

■ We may use or disclose health care information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out health care information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies**. We also disclose health care information **when required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

■ We also may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you, or to support **fundraising efforts**.

■ If admitted as a client, unless you tell us otherwise, we will list **in the client directory** your name, service area and program enrollment, your general condition and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member, and even if they do not ask for you by name.

■ We may disclose health care information about you to a **friend or family member who is involved in your medical care**, or to disaster relief authorities so that your family can be notified of your location and condition.

**Other uses of health care information**

■ In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health care information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

**Your rights regarding health care information about you.**

■ In most cases, **you have the right to look at or get a copy of health care information** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

■ If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records**, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the health care information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.

■ **You have the right to a list of those instances where we have disclosed health care information about you**, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

■ If this notice was sent to you electronically, **you have the right to a paper copy of this notice.**

■ **You have the right to request that health care information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

■ **You may request, in writing, that we not use or disclose health care information about you** for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request **but we are not legally required to accept it.** We will inform you of our decision on your request.

All written requests or appeals should be submitted to our Privacy Officer contact listed at the bottom of this notice.

The Children's Home of Cincinnati  
Lower and Upper School  
Intake Information  
2010 - 2011

**Complaints**

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer (listed below). You may also contact our Client Rights Officer-Carol Smith at 272-2800.
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer:  
Heather Ellison  
5050 Madison Road  
513-272-2800  
hellsion@thechildrenshomecinti.org

---

*Student Name*

---

*Parent/Guardian Signature*

---

*Date*