REGION 9 SCHOOL BASED HEALTH CENTER
STUDENT CONSENT FOR CONFIDENTIAL SERVICES

I, _________________________, voluntarily give the health providers at School Based Health Center permission to provide me with one or more of the following confidential services:

The services that may be provided under this confidential agreement include:

Family Planning Services
Pregnancy Testing
STI testing and treatment
Mental Health screening, counseling, and treatment
Substance abuse counseling and treatment

The school based health provider has encouraged me to involve my parent(s) and/or guardian in my healthcare; however, I am aware that it is my right to receive these services without consent of my parent or guardian.

Check all that apply:

☐ The SBHC provider may answer inquiries from my parent(s)/guardian(s) about my confidential services.
The following individuals may have access information about my confidential services: ___________________________

☐ I **do not** want my parent(s)/guardian(s) to know about my confidential services.

☐ I **do not** want my primary care provider to know about my confidential services.

By signing below, I acknowledge that:

- The SBHC provider has discussed the benefits and risks of the above services and treatment.
- The SBHC provider has discussed the risk of being sexually coerced as a minor.
- I have the right to accept or refuse these services without being denied other services from the SBHC.
- Confidentiality has been discussed with me, including the obligation to report if the provider thinks I will harm myself or others (suicide/homicide) and/or the provider knows or strongly suspects that I am being abused or neglected.
- I understand the SBHC may have to discuss my health with my parents or guardian if during my visits a condition/situation is found that can harm me and additional help is needed. I further understand I will be notified if this must happen.
- I understand that if I receive family planning services and supplies that I may be charged from a sliding fee scale. I will be responsible for these charges if they apply.
- I understand that my records will be kept confidential and will be released only as permitted or required by law and that my health information will not be released to an outside agency or person except as specified in "Notice of Privacy Practices" of which I have received a copy.
- I understand that services may be rendered by telemedicine when necessary and appropriate. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care Practitioners located at Region 9 SBHC in Ruidoso, NM. I have been informed of the risks associated with receiving services through telemedicine.

________________________________	________________	____________
Student/Patient Signature	Date of Birth	Date
________________________________	________________	____________
Witness (SBHC staff member)	Date	Title

May we contact you privately about your care? (Circle one) YES NO

Would you like to receive automatic calls, texts, or emails about upcoming appointments? (Circle one) YES NO

How would you like to be contacted?

E-mail ____ Phone ____________________ Text Message ___________________