Georgia Highlands Medical Services

Cumming Elementary - School Based Health Center

CONSENT FORM

Student Grade	Home Room Teacher	Student Last Name

In order for your child to receive services with Georgia Highlands Medical Services at Cumming Elementary School, this consent form must be completed.

I hereby voluntarily give my consent for ____
(Name of Student)
to receive health services with Georgia Highlands Medical Services at Cumming Elementary School. I further authorize any health care provider and professional staff working for the clinic to provide such medical tests, diagnoses, procedures, and treatments as are reasonably necessary or advisable for the medical evaluation and management of my child's health care.

I understand that my signing this consent allows the health care provider and professional clinic staff of Georgia Highlands Medical Services at Cumming Elementary School to provide comprehensive health services which includes physical and behavioral health services.

I authorize release of information from my son or daughter's medical record to the family doctor or primary care provider designated by me whenever necessary for his or her care including referrals and/or emergency services. I also authorize the Clinic to release information regarding treatment to third party payers such as Medicaid or other insurers for the purposes of billing or for any other reason in accordance with acceptable medical practice pursuant to the law. Medicaid and other insurers will be billed for services rendered. Charges for services rendered to students not insured will be based on a sliding fee scale. **No patients will be denied services because of inability to pay.**

Finally, I give consent for the school nurse or other designated Forsyth County School Staff to share my child's health information with Georgia Highlands Medical Services Staff and for Georgia Highlands Medical Staff to share my child's health information with the School Nurse and other designated Forsyth County School Staff.

I have read and understand the above information and give permission for my child's care as described. I also understand that I may obtain further information regarding the health services offered by the clinic by contacting the clinic at **678-965-0495.** I also understand that I have the right to withdraw this consent at any time upon written notice to the clinic director.

Name of Student/Patient (PLEASE PRINT)	Date of Birth	Date
Name of Parent or Legal Guardian (PLEASE PRINT)	Parent or Legal Guardian (SIGN)	Date
Relationship to Student	Phone Number	Primary Language

I understand that a staff member from Georgia Highlands Medical may be contacting me for more information.
To register, New Patient Forms can be found at **https://www.ghms-inc.org**