North Country Family Health Center offers **ALL** students access to our School-Based Health Centers (SBHCs) for:

- **Medical** – Annual physicals, immunizations, care for acute or chronic issues, etc.
- **Counseling** – Individual and family counseling
- **Dental** – Screenings, cleanings, fluoride treatment, and sealants

- **NO** student is turned away – regardless of insurance status.
- There are **NO** out-of-pocket cost (*no co-pays or deductibles for services provided within the school*).
- The SBHC is a great back-up plan for students who get ill while at school. No need to schedule an outside medical appointment and leave work; students can be seen right where they are – in school.
- Students who are home sick may come into the SBHCs for treatment instead of going to an urgent care or when they are unable to get into the student’s primary care provider.

**Enrollment is Easy!**

- Complete the attached enrollment packet (**ONE PER STUDENT**).
- Students who have enrolled in the SBHC in the past **MUST** update the enclosed enrollment packet **EACH YEAR**.

**South Jefferson SBHCs:**

1. **Mannsville Elementary** – Medical, Dental & Counseling
2. **Wilson Elementary** – Medical, Dental & Counseling
3. **Clarke Middle/High School** – Dental on site (medical and counseling services available at Wilson or Mannsville Elementary School-Based Health Centers).

**Please Note:**

North Country Family Health Center provides after hours care 24-hours a day, 7 days a week. If school is closed; if a school-based provider is unavailable; and over the summer months when school is not in session, please call 315-782-9450 for assistance.
Completion of this enrollment form is required each year.

Student's name: ___________________________ (LAST) (FIRST) (FULL MIDDLE) DOB: __/__/_____

Address: ___________________________ Student's school: ___________________________ Grade: ___________________________

Teacher/Homeroom: ___________________________ Sex at birth: ☐ M ☐ F Student's SS#: ___________________________

Student's primary care provider is: ___________________________ Student's dentist: ___________________________

☐ My student does not have a regular doctor ☐ My student does not have a dentist

RACE: ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Black/African American ☐ American Indian/Alaska Native ☐ Non-Hispanic or Non-Latino
☐ Asian ☐ Unreported/Refused to Report

ETHNICITY: ☐ Hispanic or Latino ☐ Other Pacific Islander

MEDICAL/DENTAL ENROLLMENT:

Medical: ☐ I would like my student to be enrolled in medical services at the SBHC
☐ I do NOT want my student enrolled in the medical/behavioral health School-Based Health Program.

☐ I would like my student to be enrolled in dental services at the SBHC
☐ I do NOT want my student enrolled in the School-Based Dental Program.

PARENT/GUARDIAN CONTACT INFORMATION:

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Name: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing address: ___________________________</td>
<td>Mailing address: ___________________________</td>
</tr>
<tr>
<td>Best phone number to reach you: ___________________________</td>
<td>Best phone number to reach you: ___________________________</td>
</tr>
<tr>
<td>Okay to leave a message or voicemail? ☐ Y ☐ N</td>
<td>Okay to leave a message or voicemail? ☐ Y ☐ N</td>
</tr>
<tr>
<td>Employer: ___________________________</td>
<td>Employer: ___________________________</td>
</tr>
<tr>
<td>Work phone: ___________________________</td>
<td>Work phone: ___________________________</td>
</tr>
<tr>
<td>Birthdate: ___________________________</td>
<td>Birthdate: ___________________________</td>
</tr>
</tbody>
</table>

Relationship to student:
☐ Father ☐ Mother ☐ Step-parent
☐ Guardian – If a guardian please provide a copy of your court order.
☐ Other: ___________________________

Email: ___________________________

Okay to email in non-emergency situations? ☐ Y ☐ N

Who does the student live with? ☐ Mother ☐ Father ☐ Both parents ☐ Other: ___________________________

Who may make health care decisions for this student? ☐ Mother ☐ Father ☐ Both parents ☐ Other: ___________________________

Biological mother’s first & maiden name: ___________________________

Preferred pharmacy with address: ___________________________

Do we have permission to call the student’s emergency contacts which you provided to school? ☐ Yes ☐ No

North Country Family Health Center, as a Federally Qualified Health Center, must ask you to complete the following:

Where did the student sleep last night? ☐ In our house/apartment ☐ In a shelter ☐ In a car/RV ☐ Do not have a place ☐ With a friend/relative

What is your household annual income $ ___________________________ How many people live in the home? ___________________________

Today’s Date: ___________________________
Permission to Disclose to Family/Other Individuals
You may authorize North Country Family Health Center’s SBHC to disclose your student’s protected health information to family members or other individuals in order to assist with their continuing care.

☐ NO, I do not give North Country Family Health Center’s SBHC permission to disclose my student’s protected health information to family or other individuals.

☐ YES, I give North Country Family Health Center’s SBHC permission to disclose my student’s protected health information to the following individuals listed below. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to expiration. Please list the individuals below:

____________________________________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________________________________

Signature of Legally Authorized Representative

Printed Name of Legally Authorized Representative

Relationship to Patient __________ Date __________

The insurance information below is REQUIRED each year.

<table>
<thead>
<tr>
<th>Medical Insurance Information</th>
<th>Dental Insurance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of parent/guardian responsible for medical bills:</td>
<td>Name of parent/guardian responsible for dental bills:</td>
</tr>
<tr>
<td>Primary Medical Insurance</td>
<td>Primary Dental Insurance</td>
</tr>
<tr>
<td>Insurance name:</td>
<td>Insurance name:</td>
</tr>
<tr>
<td>Insurance phone:</td>
<td>Insurance phone:</td>
</tr>
<tr>
<td>Insurance ID#:</td>
<td>Insurance ID#:</td>
</tr>
</tbody>
</table>

Policy Holder’s Information:
Name: ______________________________________
Social Security #: ____________________________
DOB: _________________________________________

☐ We do NOT have medical insurance

If you want to enroll your student in Medicaid or ChildHealth Plus please contact Tammy Patton, Certified Application Counselor, at 315-782-9450, x8038.

☐ We do NOT have dental insurance

<table>
<thead>
<tr>
<th>Medical/Dental History</th>
<th>Medical/Dental History</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD/Mental Health Issues</td>
<td>Chicken Pox</td>
</tr>
<tr>
<td>Asthma</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Autism</td>
<td>Growth Problems</td>
</tr>
<tr>
<td>Cancer</td>
<td>Kidney/Urinary</td>
</tr>
<tr>
<td>Cardiac Issues</td>
<td>Latex Allergy</td>
</tr>
<tr>
<td>Other: ______________________</td>
<td>Other: ______________________</td>
</tr>
</tbody>
</table>

Last physical exam was on (provide date): _____________________________

☐ Past surgeries:__________________________________________________________

☐ Past hospitalizations:_______________________________________________________

PLEASE ATTACH A COPY OF YOUR INSURANCE(S) CARD(s) IF POSSIBLE.
Does the student see a healthcare specialist? For example, a cardiologist, dermatologist, or psychiatrist etc.  □ No  □ Yes

If Yes, Name of healthcare specialist: ____________________ Phone number: ____________________

Allergies: □ No  □ Yes  If yes, what is the student allergic to and what is their reaction to the item: ____________________

Daily medications: (Name and dose) _______________________________________________________________________________

Has the student or anyone that lives in your house ever been exposed or had contact with anyone with a positive tuberculosis screen or active Tuberculosis disease?  □ No  □ Yes  If yes, who: _______________________________________________________________

Who smokes in the household? ________________________________________________________________

FAMILY HISTORY: Check any of the following a relative has had. Please include both sides of the family if you can.

<table>
<thead>
<tr>
<th>Allergies/eczema</th>
<th>Migraines</th>
<th>Migraines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mom</td>
<td>Dad</td>
<td>Sis/Bro</td>
</tr>
<tr>
<td>Asthma</td>
<td>Obesity</td>
<td>Obesity</td>
</tr>
<tr>
<td>Cancer</td>
<td>Stomach/Gi problems</td>
<td>Stomach/Gi problems</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Stroke</td>
<td>Stroke</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>History unknown</td>
<td>History unknown</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>Other:</td>
<td>Other:</td>
</tr>
<tr>
<td>Mental health disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dental Services: Please answer the questions below if you are interested in having the student receive school-based dental services.

Does the student have any developmental delays or problems?  □ No  □ Yes, explain: ____________________

Does the student have any dental concerns?  □ No  □ Yes, explain: ____________________

Has the student had any problems with dental treatment in the past?  □ No  □ Yes, explain: ____________________

Has the student ever suffered injuries to the mouth or teeth?  □ No  □ Yes, explain: ____________________

What type of water does the student drink?  □ City water  □ Well water  □ Bottled water  □ Filtered water ______

Counseling Services:
Do you have any concerns about the student’s emotions/behaviors?  □ No  □ Yes

If “Yes” would you like the student to be seen for counseling services at the SBHC?  □ No  □ Yes

If you indicated “YES” above YOU MUST COMPLETE the attached pink Request for School-Based Counseling Services Form.

CONSENT FOR SCHOOL-BASED HEALTH, DENTAL, & COUNSELING SERVICES 2019-2020

I give my consent for the student, ____________________________________________, to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Health/Dental and Counseling Programs at a School-Based Health Center. Services may include, but are not limited to, the following: comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and counseling services if needed. I also give my consent, when necessary, to have the student referred to a specialist. NCFHC has engaged Night Nurse, Inc. as the Center’s after-hours call center; Night Nurse, Inc. records all calls in order to maintain complete and accurate records of care provided to the student. Your signature below serves as consent for calls to or from Night Nurse, Inc. to be recorded. Additionally, I consent to photographs being taken of the student for inclusion in their confidential electronic medical record for diagnosis and treatment only.

In addition, I give my consent for NCFHC staff to have access to the student’s school health records and copies of the student’s most recent physical/dental exam. I give my permission for the release of the student’s medical/dental summaries to be shared with his/her healthcare provider and/or the school nurse to coordinate his or her care. I authorize insurance and/or Medicaid payments for services rendered for my dependent directly to NCFHC and the release of medical information necessary to process claims to my insurance carrier. I understand that NCFHC will share patient health information according to state and federal law for treatment, payment, and operations. I understand that every effort will be made to contact me prior to treatment. The staff of NCFHC believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in healthcare decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time. I understand that this consent form will remain in effect as long as the student is enrolled in NCFHC’s SBHC Program, unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.

Parent/guardian signature: ____________________ Date: ____________________
CONFIDENTIALITY (HIPAA) NOTICE:
North Country Family Health Center (NCFHC) is committed to maintaining the privacy of the student’s protected health information (PHI). Our promise is that the student’s medical records and other PHI will only be released from our practice with a properly executed authorization form by you, the parent, or your representative, except for certain instances. These instances are described in our Notice of Privacy Practices. The Notice is available for you to read in our office or on our website, www.NoCoFamilyHealth.org. The following are possible ways in which we may use or disclose the student’s PHI: These are only examples.

1. When our medical/dental/counseling staff is caring for the student, we will review the student’s medical/dental or counseling history.
2. Our administrative staff may audit the student’s medical/dental/counseling records for completeness and quality assurance.
3. We may need to tell your insurance plan certain information so that we may receive payment for the student’s services.

You have a right to review the Notice before signing this consent. You have the right to ask us to restrict how we use your child’s PHI. We will provide you with a form, if requested, on which you can make your written request for restrictions. We don’t have to agree to the restriction, but if we do, we are bound by the agreement. We may make changes to the Notice. Upon your request, we will provide you with any revisions.

By signing this form you consent to our use and disclosure of the child’s PHI as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing. You have the right to an accounting of the disclosures of the student’s PHI for other treatment, payment, and healthcare operations. I have been informed and understand my rights regarding the possible ways in which NCFHC may use and disclose the student’s protected health information. In addition, I acknowledge that NCFHC uses a third party to carry out healthcare functions such as appointment reminders and after hours telephone triage.

Parent/guardian signature: ___________________________ Date: ____________________________
(If the student is 18 they may sign for themselves)

Finance Policy
North Country Family Health Center’s (NCFHC) School-Based Health Program serves all patients whether they are covered by insurance or not. Services provided in the school-based setting have NO out of pocket costs. However, if the student requires services we do not provide at the SBHC – outside tests or labs – there may be out of pocket costs incurred. If you have insurance we will bill your insurance company for you. If you do not have insurance we can assist you with obtaining insurance coverage.

By signing below, you authorize NCFHC, and its representatives, to release any information they obtain, including medical information to your insurance company or their representatives to process claims for payment. I have read and understand the School-Based Finance Policy as stated above. As applicable, I authorize my insurance provider to pay North Country Family Health Center, Inc. for services rendered.

Guarantor Information – Adult responsible for all outstanding balances on the patient’s account:
Relationship to Patient: Please circle one:

Parent Custodial Parent* Foster Parent* Guardian

*Proof of legal status required.

First Middle Last

Date of Birth Social Security Number

Street Address City State Zip

Phone 1 Home or Cell? Parent/Foster Parent/Guardian

Phone 2 Home or Cell? Parent/Foster Parent/Guardian

Parent/guardian signature: ___________________________ Date: ____________________________

JMH4/8/2019
**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

**Complete this Form if the Student is NOT a Current Medical Patient of North Country Family Health Center to Ensure Coordination of Care with your Child’s Primary Care Provider**

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>Student’s Date of Birth:</th>
<th>Student’s SS#:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Student’s Address:

I, the student’s authorized representative, request that health information regarding my student’s care and treatment be released as set forth on this form. I understand that with some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I have the right to revoke this authorization at any time by writing to the student’s primary care provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my student’s treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Student’s Primary Care Provider’s Name:

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between student’s primary care provider and student’s School-Based Health Center.

Type of Information to be Released (check all that apply):

- □ Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues.
- □ Clinical records of mental health treatment
- □ HIV/AIDS-related information
- □ Records from alcohol/drug treatment programs

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

Name of Authorized Person Signing the Form: [Signature]

Relationship to the Student: [Relation]

Date: [Date]

**CONSENT FOR RELEASE OF DENTAL INFORMATION**

**Complete this Section if the Student is NOT a Current Dental Patient of North Country Family Health Center to Ensure Coordination of Care with your Child’s Dentist**

<table>
<thead>
<tr>
<th>Student’s Dentist’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between student’s dentist and student’s School-Based Dental Program.

Type of Information to be Released:
Clinical records related to the most recent dental exam, current diagnosis, and treatment of dental issues.

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

Name of Authorized Person Signing the Form: [Signature]

Relationship to the Student: [Relation]

Date: [Date]
***ONLY COMPLETE THIS FORM IF YOU WANT YOUR STUDENT TO RECEIVE COUNSELING SERVICES IN THE 2019-2020 SCHOOL YEAR***

REQUEST FOR SCHOOL-BASED COUNSELING SERVICES

<table>
<thead>
<tr>
<th>Date of Request:</th>
<th>Name of School:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

**PART I. FAMILY INFORMATION**

Child/Adolescent being referred (full name): __________________________ DOB: ____________

Parent/Guardian(s) requesting counseling services: __________________________

Relationship to child: ___Parent ___Guardian ___Other__________ Sex at Birth: M F

Address: ____________________________________________________________ Phone: __________

Home: ___________________ Cell: __________ Work: ____________________ OK to call work? Y N

Who else may we talk to in the home when we call? ____________________________

Other residents of the home besides person requesting service and child being referred (please print):

<table>
<thead>
<tr>
<th>FULL NAME:</th>
<th>*AGE/GENDER</th>
<th>FULL NAME:</th>
<th>*AGE/GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________   ___</td>
<td>____________________   ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____________________   ___</td>
<td>____________________   ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____________________   ___</td>
<td>____________________   ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>____________________   ___</td>
<td>*(A=Adult)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*(A=Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>*(A=Adult)</td>
</tr>
</tbody>
</table>

**PART II. REASON FOR REQUEST**

What are the parent/guardian concerns about this child?

Do you have concerns with your child at school?

___Poor Academics

___Suspensions/Detentions

___Has IEP

___Attention concerns

Comments: ____________________________

**PART III. OTHER INFORMATION**

Insurance:

___Medicaid

___CHP

___Other___________________________

Date of Last Physical Exam:___________________

Name of Student’s Primary Care Provider: __________________________

**PART IV. SIGNATURES**

I have received the letter describing the mental health referral process and a copy of the community resource list. I understand that a parent/guardian’s failure to attend and participate in the mental health evaluation/counseling services can affect the provider’s ability to treat my student and can result in a referral to services elsewhere.

_________________________________________ ______________________
Parent/Guardian Signature Date

NCFHC: HL 4.3.19
I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called Health\(_e\)Connections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Health\(_e\)Connections is a not-for-profit organization that shares information about people’s health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Health\(_e\)Connections website at http://healtheconnections.org/.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

**My Consent Choice.** ONE box is checked to the left of my choice.

- 1. **I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through Health\(_e\)Connections to provide health care services (including emergency care).

- 2. **I DENY CONSENT** for the Organization named above to access my electronic health information through Health\(_e\)Connections for any purpose, even in a medical emergency.

If I want to deny consent for all Provider Organizations and Health Plans participating in Health\(_e\)Connections to access my electronic health information through Health\(_e\)Connections, I may do so by visiting Health\(_e\)Connections website at http://healtheconnections.org/ or calling Health\(_e\)Connections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.
Details about the information accessed through HealthConnections and the consent process:

1. **How Your Information May Be Used.** Your electronic health information will be used only for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealthConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental Health conditions
   - Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealthConnections. You can obtain an updated list at any time by checking HealthConnections website at http://healthconections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient’s consent for certain public health and organ transplant purposes. These entities may access your information through HealthConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealthConnections website at http://healthconections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HealthConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealthConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealthConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.