School-Based Wellness Center

Carrie Downie Elementary
1201 Delaware Street
New Castle, DE 19720
Phone: (302 429-4083

Eisenberg Elementary
27 Landers Lane
New Castle, DE 19720
Phone: (302)429-4083

New Castle Elementary
903 Delaware Street
New Castle, DE 19720
Phone: (302)429-4083

Pleasantville Elementary
16 Pleasant Place
New Castle, DE 19720
Phone: (302)429-4083

Wilmington Manor Elementary 200 E. Roosevelt Avenue New Castle, DE 19720
Phone: (302)429-4083

Castle Hills Elementary
502 Moores Lane
New Castle, DE 19720
Phone: (302)429-4083

Wilbur Elementary
4050 Wrangle Hill Road
Bear, DE 19701 Phone:
(302)429-4083

Southern Elementary
795 Cox Neck road
New Castle, DE 19720
Phone: (302)429-4083

Dear Parents/Guardians:

The School-Based Wellness Center (SBWC) is a partnership between Nemours Children's Health and Colonial School District. This letter is an invitation to sign up your child in the SBWC.

Health care is provided in the SBWC at your child's school by a Physician or Nurse Practitioner and a Psychologist or a Licensed Clinical Social Worker/Licensed Professional Counselor of Mental Health.

To sign up your child in the SBWC, you need to provide the following:

- Up-to-date insurance information is needed if your child is insured. (Note: No co-pay, co-insurance or deductible will be charged to you and no one will be turned away based on ability to pay).
- A completed Consent Form (included in this packet).
- A completed Student Registration Form and Health History Form (included in this packet) The completed enrollment/registration forms should be returned to the SBWC as soon as possible.

SBWC services offered:

- Physicals
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses and injuries
- Counseling (individual, family, and group)
- Crisis intervention and suicide prevention
- Health education/risk reduction

Please know that your child's pediatrician or family doctor will still be your child's main doctor. The SBWC does not take the place of your child's pediatrician or family doctor, and SBWC doctors and nurses will work with your child's main doctor to care for your child. The SBWC offers services that may add to the care provided by your main doctor. When appropriate, and with your permission, we will try to share medical information with your child's doctor to prevent any duplication of health care services, and to take good care of your child. If your child does not have a doctor, we can help you find one.

We hope that you will register your child in the SBWC. Then, together with you and your child's main doctor, we can work towards keeping your child healthy and in school. Please encourage your child's pediatrician or family doctor to call the SBWC with questions. If you have questions or need more information, please call the School-Based Wellness Center.

Sincerely,

Denise Hughes
Program Manager, School Initiatives
(302) 332-2642

Patient Name:
MRN:
DOB:

SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES

I_____, give my consent for _____

(Parent/Legal Representative of Student) (**Name of Student)**

to receive health services at the School-Based Health Center administered by **Nemours Children's Health (Nemours).**

Services Provided:

- Comprehensive health assessments (for students without a primary care physician)
- Immunizations
- Diagnosis and treatment of minor, acute and chronic medical conditions
- Referrals to and follow up for specialty care, oral and vision health services
- Behavioral Health, counseling, and treatment
- Referral to behavioral/mental health services including emergency psychiatric care, community and support program

In consenting to permit my student to participate in the School-Based Health Center, I acknowledge and agree to the following:

1. I have had the opportunity to receive and review the Nemours Notice of Privacy Practices brochure which is included within the packet.

2. ***I understand*** that insurance may be billed for covered services, and I agree to provide insurance information before services are provided.

3. ***I understand*** that the School-Based Health Center shall not charge co-pays or any other out-of-pocket fees for use of its services.

4. ***I understand*** this consent may be revoked in writing at any time, except for any action already taken, prior to revoking this consent. The revocation must be in writing and sent to the School-Based Health Center associated with my student's care.

5. ***I understand*** the School-Based Health Center works in collaboration with Colonial School District. As a part of this collaboration both parties can review and share all written and verbal information concerning my child on a need-to-know basis, including school and medical records. They can also discuss pertinent medical, behavioral, and/or social needs with Colonial School staff in the best interest of the child and family.
6. ***I understand*** that information, including recordings (photographs, video, electronic or audio media), may be collected, used, and shared with others only as necessary for:

SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES

- Coordinating treatment with healthcare providers;
- Ensuring providers we refer you to have all the necessary health information;
- Eligibility, billing, claims management, medical necessity, and utilization review;
- Required reporting of diseases or injuries such as communicable diseases;
- Required reporting to registries such as cancer and immunization; and
- Inclusion in Health Information Exchanges.

7. ***I agree***, that school staff can accompany my child for a medical exam.

8. ***I agree*** that all information provided on the registration Health History Form and this consent is accurate and complete.

9. Telehealth
    - I understand that "telehealth" is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as my provider.
    - I understand that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.
    - I understand that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my care team.
    - I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. In the event of a technical failure, I understand that I should immediately contact my provider's office, or, if it is an emergency, dial 911.
    - I understand that laws protecting the confidentiality of my medical information also apply to telehealth and that Nemours uses security protocols to help protect my privacy and ensure my confidential communications are sent only to the intended care team member(s).

SCHOOL-BASED HEALTH CENTER
PARENT/STUDENT CONSENT FOR SERVICES

- I understand that Nemours will not record the video or audio of my telehealth visit without my consent at the time of the recording.
- I consent to have Nemours obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.
- I understand that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

10. My student and I have read this consent carefully. All my questions, if any, have been answered to my satisfaction. I understand that I may call the School-Based Health Center Coordinator if I have any questions before or after I sign this Consent for Services.

By signing below, I certify that I am the parent or legal representative of the student named above and have read the above consent statements about services offered at my student's School-Based Health Center and voluntarily agree to have my student participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

Signature of Parent/Legal Representative:_____

Print Name of Parent/Legal Representative: _____

Relationship to Patient: _____Date: _____Time:_____(AM/PM)

Valid for one year from the date above.

*Nemours includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Bryn Mawr; and Nemours Children's Hospital, Surgery Center, Deptford; and all entities operating under the name Nemours Children's Health.

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

School-Based Health Center Patient Registration Form

School: (Please circle)			
Carrie Downie Elementary	Castle Hills Elementary	Eisenberg Elementary	New Castle Elementary
Pleasantville Elementary	Southern Elementary	Wilbur Elementary	Wilmington Manor Elementary

Grade: K 1 2 3 4 5	Student ID (lunch) number:

Patient's Last Name:	First:	Middle:

Identified Sex:	Male	Female	Transgender Male	Transgender Female	Decline to Answer

Address: City: State: Zip Code:	Birthdate:
Language (Circle one) English Spanish Sign French Other	Nemours Patient (Circle one): Yes No
Speak English? Not at all Not well Well Very well Refused	Interpreter Needed (Circle one): Yes No

Ethnicity (Circle one):	Puerto Rican	Mexican, Mexican American, Chicano/a	Cuban Origin
	Non-Hispanic or Latino	Another Hispanic, Latino, or Spanish	Refused

Race (Circle one):	American Indian or Alaska Native	Asian Indian	Black or African American	Chinese
	Filipino	Guamanian or Chamorro	Japanese	Korean
	Native Hawaiian	Samoan	White or Caucasian	Vietnamese
	Other Asian	Other Pacific Islander	Other	Refused

Parent 1 Full Legal Name:	Date of Birth:	Home Phone#:
Address:	Cell Phone#:	
City: State: Zip Code:	Work Phone#:	
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody		
Parent 2 Full Legal Name:	Date of Birth:	Home Phone#:
Address:	Cell Phone#:	
City: State: Zip Code:	Work Phone#:	
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody		
Legal Representative Name (if not mother or father): Relationship to Student:	Date of Birth:	Home Phone#:
Address:	Cell Phone#:	
City: State: Zip Code:	Work Phone#:	
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody		

If you are not available, is there another person we can contact to make decisions?

Contact 1 Name:	Contact 1 Phone #:
Contact 2 Name:	Contact 2 Phone #:
Contact 3 Name:	Contact 3 Phone #:

Patient Name:
MRN:
DOB:

School-Based Health Center Patient Registration Form

► **Insurance Information** (REQUIRED) –
Send in a Copy or take a picture and email Front and Back of Insurance Card to (SBHC@nemours.org)

Source of payment for care, please check off one of the following:

_____No Insurance

_____Medicaid Provider: _____

Medicaid Number: _____

_____Commercial Insurance: _____

Policy Number: _____
Subscriber Name: _____
Relationship to Student: _____
Subscriber Birthdate: _____

_____Delaware Healthy Children Program

Secondary Insurance Information:

_____Medicaid Provider: _____

Medicaid Number: _____

_____Commercial Insurance: _____

Policy Number: _____
Subscriber Name: _____
Relationship to Student: _____
Subscriber Birthdate: _____

Key: K: Kindergarten; ID: Identification; #: Number

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NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

School-Based Health Center Health History Form

A complete and accurate health history is needed for the School-Based Health Center staff to provide high quality care. Please complete this form to the best of your ability and print all information.

Student's Name_____DOB_____Grade_____

(Last) (First) (MI)

Does your child have any allergies? (food, medication, latex)

□ Yes □ No If yes, please list? _____

Please provide the following information about medicines your child is taking.

Name of medicines	Reason taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Provider Name: _____

Date of Last Physical: _____

Please indicate if your CHILD has had any of the following:

□ ADD/ADHD	□ Chicken Pox	□ Hearing Problems	□ Seasonal Allergies
□ Anemia	□ Developmental Delay	□ Heart Disease	□ Seizures
□ Asthma	□ Diabetes	□ Kidney/Bladder Disease	□ Sickle Cell
□ Autism	□ Ear Infection	□ Pneumonia	□ Stomach/Intestinal Problems
□ Birth Defect/Genetic Problem	□ Eczema	□ Prematurity	□ Tuberculosis
□ Cancer	□ Food Allergies	□ Reoccurring Urinary Tract Infection	□ Vision Problems
□ Cerebral Palsy	□ GERD	□ Rheumatic Heart Disease	

Key: ADD/ADHD: Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder; GERD: Gastroesophageal reflux disease

If any of the above are checked, please give more detail. _____
_____

Has your child ever been hospitalized or received counseling for emotional health?

□ Yes □ No If yes, when? _____ Where? _____

Reason: _____

Patient Name:
MRN:
DOB:

School-Based Health Center Health History Form

Please check any of the following illnesses that your CHILD's FAMILY MEMBERS (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and indicate which family member next to the illness.

□ Alcoholism/Drug Abuse _____
□ Anemia _____
□ Asthma _____
□ Cancer _____
□ Congenital Hearing Loss _____
□ Depression _____
□ Diabetes _____
□ Genetic Disorder _____
□ Heart Disease _____
□ Hypertension _____
□ High Cholesterol _____
□ Kidney/Bladder Disease _____
□ Liver/Gallbladder Disease _____
□ Mental Illness _____
□ Obesity _____
□ Seizures _____
□ Sickle Cell _____
□ Sleep Disorder _____
□ Stroke_____
□ Unexplained Death _____
□ Other _____

Parental/Legal Representative Concerns

If you have any concerns, please schedule a visit at the School-Based Health Center or you can call us (1-302-429-4083) to discuss your concerns.

If you would like assistance with establishing insurance, finding a doctor, or a dentist, please call the School-Based Health Center.

Completed By Signature: _____ Date: _____ Time: _____AM/PM

Completed By Printed Name: _____

Reviewed By Signature: _____ Date: _____ Time: _____AM/PM

Reviewed By Printed Name: _____

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Social Determinants of Health

Current as of: 12/08/2020

Patient's Name: Date of Birth: Today's Date:

Here at Nemours, we want to provide the best possible care for your child and your family. Many things in your life can impact your child's health, like what you eat, how difficult it may be to get here, your job, and whether you are able to pay for medicine or medical treatment. With these questions, we are learning how we can better serve children and families. These questions may be personal, but like all your medical records, anything you share will be kept private and confidential. We are required by law to report any abuse.

Would you like to complete the form?

☐ Yes ☐ No

1. In the past 12 months, were there times the food you bought didn't last and you didn't have the money to buy more?

☐ Yes ☐ No

2. In the past 12 months, have you ever had trouble paying for a doctor, dentist, or medicine for you or your child?

☐ Yes ☐ No

3. In the past 12 months, did your child ever go without medicine or miss a medical appointment because you didn't have a way to get to the pharmacy or doctor?

☐ Yes ☐ No

4. In the past 12 months, has your utility company ever shut off your service because you were unable to pay your bill (electric, gas, water, heat, or phone)?

☐ Yes ☐ No

5. Is reliable internet a concern?

☐ Yes ☐ No

6. In the past 12 months, have you or your child ever had to stay in a shelter, stay with others, in a hotel, live outside on the street, on a beach, in a car, or in a park, even for 1 night?

☐ Yes ☐ No

7. Currently, do you have any problems in the place where you live like mold, bugs, ants or mice, lead paint or pipes, lack of heat or air conditioning, not working or lack of smoke detectors, oven or stove, water leaks or other repair issues?

☐ Yes ☐ No

8. Are you concerned about losing your housing?

☐ Yes ☐ No

9. Do you have any concerns about your fostering/kinship or custody arrangement or your family's immigration status?

☐ Yes ☐ No

10. In the past 12 months, have you or any other family member been hit, threatened, abused, or bullied?

☐ Yes ☐ No

11. Do you have any concerns about your neighborhood with safety, gun violence, cleanliness or crime?

☐ Yes ☐ No

12. Do you sometimes have a hard time understanding what your doctor or nurse is telling about your child's health or medications?

☐ Yes ☐ No

13. Do you sometimes have a hard time understanding doctor instructions and medical paperwork?

☐ Yes ☐ No

14. In the past 12 months, has there been a time when you or your child needed help and you had no one to call on (such as with transportation or childcare)?

☐ Yes ☐ No If "yes", could you explain?

Are you interested in receiving information to address these needs?

☐ Yes ☐ No

NEMOURS CHILDREN'S HEALTH

Effective Date: **July 6, 2021**

Notice of Privacy Practices

The Nemours Notice of Privacy Practices (Notice) describes how medical information about you or your child may be used and disclosed and how you can get access to this information. **Please review it carefully.**

It's Your Information

Your health record belongs to Nemours, but it's YOUR information.

It's Our Responsibility to...

- Maintain the privacy and security of your health information.
- Follow the duties and privacy practices described in this Notice.
- Give you a copy of this Notice and be available to you if you have any questions or concerns.
- Use or share your information only as described here unless you tell us we can. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Notify you promptly if your information has been compromised.

To learn more about your rights under HIPAA, please visit the https://www.hhs.gov/hipaa/for-individuals/index.html.

NEMOURS
CHILDREN'S HEALTH

Well Beyond Medicine

Your Health Information Rights

- **Access to Records**
  You can ask to receive an electronic or paper copy of your medical record and other health information. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

  In rare circumstances, we may deny your request along with an explanation. If we deny your request, you may request a review by another health care professional, who will be chosen by Nemours, and we will comply with the outcome of the review..

- **Amend Your Medical Records**
  You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say 'no' to your request, but we'll tell you why in writing within 60 days.

- **Request Restrictions**
  You can ask Nemours not to share your health information for treatment, payment or health care operations. You can also request a restriction of release to people involved in your care. For instance, you can request that we do not share information about a procedure or treatment.

  We are not required to agree to your request, but we will try to do so and will let you know if we can. If we do agree to the restriction, we will comply with it unless the information is needed to provide treatment.

  If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Requests for Confidential Communications**
  We may communicate with you through email, text messages, phone calls and our patient portal. Emails, text messages or electronic communications outside of our portal may not be encrypted or secure and could be intercepted by another person or organization. We will assume you understand these risks if you provide us with a mobile phone number or email address to communicate with you.

  You can always ask us to contact you about health matters in the way that makes you comfortable. For example, you can ask that we only contact you at work or by mail. We will say "yes" to all reasonable requests.

- **Corrections to Protected Health Information**
  If you believe the information we have is incorrect or incomplete, you may request an update.

  Nemours will review the request and notify you of our decision in writing. If approved, Nemours will update the information. We will also make a reasonable effort to notify people to whom the information was released.

  In case we deny the request, Nemours will provide the reason for the denial within 60 days and instructions on how to appeal the decision.

- **Accounting of Disclosures**
  You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why.

  We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.

- **Personal Representatives**
  If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

How might Nemours use and share my information?

We may use and share your health information for the following purposes and examples:

- **To ensure you get the best treatment possible.**
  We will share details of your diagnosis and treatment information with your other health care providers. We will share diagnosis and treatment information with Health Information Exchanges so that you don't experience unnecessary delays in your care when you are treated by providers who participate in those exchanges. You can contact the Privacy Office to prevent your information from being shared with Health Information Exchanges. We will share your diagnosis and treatment information within Nemours as needed to provide the best care possible.

- **To receive payment for the services we provide.**
  We give your insurance company information so they can pay us for services provided to you. Planned treatments may be shared so that we can get approval for your needed services.

- **To improve the delivery of our care and operations.**
  We may use all, or part, of your health information to improve treatment methods. We will use your health information to offer the best services to our patients and families. We may share your health information with our business partners to evaluate our services, programs, and facilities.

- **To inform you of health-related services and benefits:**
  - so that you know about new Nemours services or locations
  - to send you educational materials about your illness or condition
  - to announce the addition or departure of a doctor or other care provider
  - to remind you about appointments and prescription refills
  - to tell you about special events and fundraising activities

- **To collaborate with other health care organizations and providers.** We do this to coordinate and provide care, reduce costs, improve quality, and provide increased value for the services we provide. Examples of these partnerships are:
  - Clinically Integrated Networks (CIN),
  - providing services at other health care organizations, and
  - other Organized Health Care Arrangements (OHCA).

What information might we share without you agreeing or objecting?

- **If Required by Law.** If federal, state or local laws require us to share your health information, we are compelled to do so.
- **Public Health Purposes.** We may share your health information for public health activities. Public health activities are things such as:
  - preventing or controlling disease, injury or disability
  - reporting births and deaths
  - reporting reactions to medications or problems with products
  - notification of recalls of products a person may be using
  - notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- **Abuse or Neglect.** We may share protected health information to a public health authority or other government authority that is authorized by law to receive reports of abuse, violence or neglect.
- **Health Oversight Activities.** We may share your health information to an oversight agency for activities authorized by law. Examples are audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws and regulations.
- **To Avert a Serious Threat to Health or Safety.** Nemours may use or disclose your health information when necessary to prevent a serious threat to the health and safety of the public, another person, or you.
- **Organ and Tissue Donation.** If you are an organ donor, we may release your health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate donation and transplantation.
- **Workers' Compensation.** We may release your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Military and Veterans.** If you are a member of the armed forces, Nemours may release your health information as required by military command authorities.
- **Judicial and Administrative Proceedings.** We may share your health information in response to a court or administrative order, subpoena, discovery request or other lawful process by someone else involved in the dispute.
- **Coroners, Medical Examiners and Funeral Home Directors.** We may release your health information to a coroner or medical examiner. For example, this may be necessary to identify a deceased person or determine the cause of death. We may also release your health information to funeral directors to carry out their duties.
- **Correctional Institutions.** We may share or release your health information with a correctional institution or law enforcement official if you are in their custody. This is necessary to provide you with health care, to protect the health and safety of others, or for the safety and security of the correctional institution.
- **National Security and Intelligence Activities.** We may release your health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may share your health information to government law enforcement so they may provide protection to elected constitutional officers, heads of state or to conduct investigations.
- **Law Enforcement.** We may share your health information if asked to do so by law enforcement officials:
  - trying to identify or locate a criminal suspect, fugitive, material witness or missing person investigating a crime.
  - investigating a death we believe may be the result of suspicious conduct.
  - in necessary circumstances to report a crime — including the location, victims, or the identity, description, or location of the person who committed the crime.
- **Research.** We conduct and participate in many research activities. All research projects must be approved through a special review process to protect patient safety, welfare and privacy. The review process determines whether the request for your information has met federal and state requirements to protect your information.

What health information may Nemours use and disclose if you do not object?

- **Marketing.** Nemours may use your health information to send you educational materials related to your illness or condition, to advise you about certain treatment alternatives related to your illness or condition, or to tell you about certain health-related benefits and services related to your illness or condition. We will never sell your health information unless you give us written permission.
- **Fundraising.** We may contact you for fundraising purposes, but you can tell us not to contact you again.
- **Hospital Directory.** We will include limited information about you in our hospital directories while you are visiting. This is so your family, friends, and clergy can contact or visit you in the hospital. It is your choice whether you want your information included in our directory. At any point during the stay you can request that your information be excluded from the directory.

- **Family Members and Others Involved in Your Health Care.** We may share your health information with your friend(s) or family member(s) involved in your medical care. We will do so if give us permission or, if in our professional judgement, it is in the best interest of your health.
- **Disaster Relief.** We may disclose health information about you to organizations assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

What about other uses of my health information?

Uses and disclosures of your health information not covered by this Notice or federal or state laws that protect your health information will be made only with your written authorization.

Can I revoke my authorization to disclose information?

If you authorize us to use or disclose your health information, but you change your mind, you can revoke your authorization at any time by submitting your request to the Nemours Privacy Office using the contact information below. We will stop sharing your information immediately upon processing your request. However, we will be unable to recall/redact any information we have already shared.

How do I contact the Nemours Privacy Office?

You can reach the Nemours Privacy Office at (800) 472-6610, email privacy@nemours.org, or contact us by mail at this address:

The Nemours Privacy Office, Attn: Chief Privacy Officer
10140 Centurion Parkway North, Jacksonville, FL 32256

Where can I get a copy of the Notice of Privacy Practices?

You can ask for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. Please ask any Nemours Associate and we will provide you with a copy promptly.

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website. (https://www.nemours.org/privacy-practices.html).

What if I believe my health care information rights have been violated and I want to file a complaint?

We will address every question, comment, or concern promptly. This is a right afforded to you and Nemours will not retaliate against you for filing a complaint. You may file a complaint directly with Nemours to resolve any concerns or questions about your health information. The Privacy Office can be reached by calling (800) 472-6610, through email to privacy@nemours.org, or by mail at this address:

The Nemours Privacy Office, Attn: Chief Privacy Officer
10140 Centurion Parkway North, Jacksonville, FL 32256

You may also file your complaint with the Department of Health and Human Services in writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

If you wish to remain anonymous, call the Nemours Compliance Hotline (866) 636-4685.

What if my information is lost or stolen from Nemours?

The Nemours Privacy Office will contact you, informing you what information was lost and how best to protect yourself.

Language Assistance

Language assistance services are available to you, free of charge. Please call (800) 851-5691 for help. Find more information in our https://www.nemours.org/notice-of-nondiscrimination.html.

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