Easterseals Florida - Camp Challenge Weekend Camp & Spring Week Camp Application 2020-2021

Easterseals Florida is happy to announce the return of our camping programs with the **2020-2021 weekend and weeklong camp** schedule & application. We want to thank you for your interest in attending our camp this year and have many exciting programs and activities planned for your enjoyment. Please read the entire application carefully as there are significant changes.

Please Note: There will be **seven (7) upcoming Weekend Camps** before summer camp 2021:

Fall A (October 23-25, 2020)
Fall B (November 20-22, 2020)
Winter A (December 18-20, 2020)
Winter B (January 22-24, 2021)
Winter C (February 19-21, 2021)
Spring A (March 19-21, 2021)
Spring B (April 16-18, 2021)

NEW - We WILL be offering SPRING Week-Long Camp March 14-21, 2021**

There will be NO WINTER Week-Long Camp this year.
Due to COVID-19, there are NO discounts for multiple weekends this year – see page 6 for full Fee & Payment Information.

Once you have completed in full all the enclosed forms, please send them to:
Easter Seals Camp Challenge, 31600 Camp Challenge Road, Sorrento, Fl, 32776.

Please be sure to have the following items completed and enclosed in your application packet:

☐ Checklist – Page 1

☐ Completed Application form with legal guardian signature(s) – Pages 2-5

☐ Fee and Payment Information with Signatures – Pages 6

☐ Medical and Liability release/Insurance information form – Page 7 **(ALL CAMPERS)**

☐ ALL Campers MUST have a physical and return the **Camper Medical Form** prior to attendance at the first weekend camp. This must be completed by a licensed physician. - Pages 8-9

☐ Privacy Practices (DO NOT RETURN – KEEP FOR YOUR RECORDS) – Pages 10-11

☐ Check made payable to "**Easter Seals Florida, Inc.**" for full amount.

We ask that you provide as much detail as possible so that we can best meet the needs of the camper and provide the most enjoyable experience possible. **Please note: We cannot fully process an application and confirm acceptance to the program without full payment and a completed application packet. For our record keeping purposes all applications must be fully completed with all questions answered and spaces signed/initialed. Incomplete applications will be returned and acceptance into the program will not be guaranteed. You will receive confirmation within 2 business days that we have received your application.**

Email: camp@fl.easterseals.com or Phone: (352) 383 – 4711 www.easterseals.com/florida

Weekend Camps:	**Check-in Friday – 4:00pm-5:30pm (dinner will be served)** ****Check-in times will be staggered**** **Check-out Sunday – 4:00pm-5:00pm (lunch will be served)**
Spring Weeklong Camp:	**Check-in Sunday – 4:00pm-5:30pm (dinner will be served)** ****Check-in times will be staggered**** **Check-out Sunday – 4:00pm-5:00pm (lunch will be served)**

Preferred check-in window ☐ 4-4:30pm ☐ 4:30-5pm ☐ 5-5:30pm

Weekend Camp Dates	Mark "✓" below to attend
☐ Friday, October 23 – Sunday, October 25, 2020	☐ Friday, November 20 – Sunday, November 22, 2020
☐ Friday, December 18 – Sunday, December 20, 2020	☐ Friday, January 22 – Sunday, January 24, 2021
☐ Friday, February 19 – Sunday, February 21, 2021	☐ Friday, March 19 – Sunday, March 21, 2021*
☐ Friday, April 16 – Sunday, April 18, 2021	☐ SPRING WEEKLONG CAMP March 14-21, 2021*

***Select only March Weekend or Spring Weeklong Camp**

Section I: General Information

Camp Challenge

Camper's Full Name:_____

Address: _____

Street City State Zip County

DOB: ____/____/____ **Age**: _____ **Sex**:_____ **Height**: _____ **Weight**: _____ **Ethnicity**: _____

Phone: (_____)_____ **Email**: _____

Caregiver Email if Different:_____

Is this your first-time attending Camp Challenge? ☐ Yes ☐ No

If so, how did you hear about Camp Challenge? _____

Veteran Status: Active Duty ☐ Veteran ☐ Family Member of a Veteran ☐ None ☐

Name of Individual(s) That Camper May Be Released To: _____

	Party responsible for camper PAYMENT	EMERGENCY CONTACT during camp session: ☐ Same as Payer
Name		
Address		
Phone		
Relationship to Camper		

For ALL Campers - Please answer all questions below.

Camper's Disability (please check all that apply):

☐ Down Syndrome	☐ Cerebral Palsy	☐ Spina Bifida
☐ Autism/Spectrum Disorder	☐ Asperger's Syndrome	☐ ADHD/ADD
☐ Metabolic Disorder	☐ Muscular Dystrophy	☐ Prader Willi Syndrome
☐ Intellectual Disability	☐ Seizure Disorder	☐ Hearing Impaired
☐ Visually Impaired	☐ Other (Please List)	

Camp Challenge provides a 3:1 camper to staff ratio. Understanding that there may be brief times, such as during transitions, meal times, or for personal care needs a lower ratio may needed temporarily. Based on the camper's disability and needs, is the camper able to maintain overall behavior in a 3:1 camper to staff ratio? ☐ Yes ☐ No

Section I: Behavior

Can camper communicate wants and needs effectively to others? ☐ Yes ☐ No

How does camper communicate? (Please check all that apply):

☐ Verbally ☐ Sign Language ☐ Electronic Device ☐ Gestures
☐ Other

How does camper adjust to new situations/new people?

_____
_____

Does the camper have any of the following behaviors?

☐ Self Injury ☐ Spitting ☐ Biting ☐ Property destruction
Elopement: ☐ Physical Aggression ☐ Inappropriate language ☐ Refusal to follow directions
☐ Running far away (kicking/hitting/punching)
☐ Leaving the area
☐ Other _____

Does camper have any behavioral concerns? ☐ Yes ☐ No

Please describe in detail when these behaviors typically occur, what they look like, how long they last, and what you typically do to calm the situation:

_____
_____

Are there known triggers for any behaviors? ☐ Yes ☐ No

If yes, please explain:

_____
_____

Does camper have any routines that are significant for camp staff to be aware of? ☐ Yes ☐ No

If yes, please explain:

_____
_____

Are transitions (moving from one activity/place to another) a challenge for camper? ☐ Yes ☐ No

If yes, please explain and include details on strategies that are successful:

_____

Does the camper have any fears? ☐ Yes ☐ No If yes, please list: _____

Does the camper have any bedtime rituals or routines? ☐ Yes ☐ No

If yes, please explain: _____
_____

Does the camper use bedrails? ☐ Yes ☐ No

Section II: Personal Care

Does the camper wear briefs/diapers? ☐ Yes ☐ No

Does the camper need assistance bathing? ☐ Yes ☐ No

Does the camper need assistance brushing their teeth? ☐ Yes ☐ No

Does the camper need assistance transferring? ☐ Yes ☐ No

Does the camper need assistance with eating? ☐ Yes ☐ No

Does the camper need bed rails to sleep? ☐ Yes ☐ No

Adaptive Equipment: Does camper use any of the following? (Check all that apply)

☐ **Glasses** ☐ **Hearing Aids** ☐ **Orthotic Leg Braces** ☐ **Dental Retainers/Devices** ☐ **Walker/Cane**
☐ **Wheelchair (☐ Electric / ☐ Manual)** ☐ **Other_____**

Special Instruction: _____

_____
_____

Section III: Activities

General Activities

Please list the activities (sports, hobbies, etc) the camper currently participates in:

_____

Does the camper have any adaptive equipment to assist with participation in activities?
☐ Yes ☐ No If yes, please explain:

_____

Does the camper have any limitations to being outside in the sun/heat for approximately 45 minutes at a time?
☐ Yes ☐ No If yes, please explain:

_____

Please list any additional likes or dislikes pertaining to the recreation of the camper:

_____

_____

Swimming: Camper may participate _____ (initial)
Please check all that apply regarding camper's swimming ability.
☐ Swims well without assistance ☐ Swims with assistance ☐ Non-swimmer
☐ Other information pertaining to swimming/pool:

_____

Nature: Camper may participate _____ (initial)
Does the camper have any fear of animals? If yes, please explain: ☐ Yes ☐ No

_____

Is the camper allergic to any animals? ☐ Yes ☐ No
If yes, please list: _____

Can the camper sit with assistance for approximately 30 minutes for a tractor ride? ☐ Yes ☐ No
Special considerations: _____

_____

Sports & Games (including target range): Camper may participate _____ (initial)
What sports has the camper participated in previously?

_____

Does the camper participate well in group activities? If no, please explain: ☐ Yes ☐ No

_____

Challenge/Ropes Course: Camper may participate _____ (initial)
Has the camper ever done a challenge course/zip line before? ☐ Yes ☐ No
Is the camper afraid of heights? ☐ Yes ☐ No

Arts & Crafts: Camper may participate _____ (initial)
Are there any behaviors or limitation that would prevent the camper from participating in arts & crafts?
☐ Yes ☐ No If yes, please explain:

_____

_____

What types of crafts or art (drawing, painting, making beaded necklaces, etc.) does the camper enjoy?

_____

Section IV: Health History

General Health: Does camper have any of the following:

☐ Asthma ☐ Seizures ☐ Frequent Ear infections ☐ Diabetes
☐ Heart Problems ☐ Bleeding/Clotting disorders ☐ Mental Health Concerns ☐ Circulatory Problems
☐ Other: _____

List Any Recent Operations, Serious Injuries Or Recurring Illnesses: _____

Has Camper Been Hospitalized Within The Last 12 Months? ☐ Yes ☐ No

If Yes, Please Explain: _____

Has Camper Been Treated In An Emergency Room Within The Last 12 Months? ☐ Yes ☐ No

If Yes, Please Explain: _____

Allergies:

☐ Food: _____ ☐ Insects: _____
☐ Plants: _____ ☐ Medicines: _____
☐ Other _____

Seizures: Does camper have seizures/seizure disorder? ☐ Yes ☐ No

Type of seizures

☐ Grand Mal
☐ Absence (loss of consciousness)
☐ Myoclonic/Clonic (jerking)
☐ Tonic (muscle stiffness/rigidity)
☐ Atonic [loss of muscle tone]

Frequency of seizures: _____
Duration of seizures: _____
Date of last seizure: _____
Are seizures controlled with medication? ☐ Yes ☐ No
When to Notify Emergency Contact? ☐ Every Time ☐ Over 5 Minutes ☐Other_____

Please describe what camper's seizure looks like (include behavior before, during and after event):

_____
_____

Medications: (All medications must be separated in to individual dose containers for the length of the campers stay. Please also bring the original prescription bottles.)

☐ **List any medications and the times given on the Camper Medication Record Form included.**

Are there any special techniques used or information that may be helpful to camp staff regarding administering of medications to camper? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Any change in campers medications in the last 90 Days? ☐ Yes ☐ No
If Yes, Please explain:

_____
_____

Please Describe Any Additional Medical Concerns:

_____
_____
_____

Camper's Name: _____

Physician's Name: _____ Phone # ( )_____

Application Completed By: _____ _____ Date: _____
Print *Signature*

Relationship to Camper: _____ Phone #: ( ) _____

Section V: Fees & Payment

Weekend Camp: $359 for each weekend camp session

Weeklong Spring Camp will begin at 4:00pm Sunday, March 14, 2021 and check-out will be Sunday, March 21, 2021 from 4:00-5:00pm. The cost for the weeklong camp is $1,179

NO financial aid is available.

The $359 fee is due at the time of registration for EACH session.
LATE FEE: If fees are not paid 21 days prior to the start of the session LATE FEES will apply as follows:
14-20 days prior to session $384 ($25 late fee added)
Less than 14 days prior to session: $409 ($50 late fee added).

Please Check Sessions Attending:

Fall A	**October 23-25, 2020**	
Fall B	**November 20-22, 2020**	
Winter A	**December 18-20, 2020**	
Winter B	**January 22-24, 2021**	
Winter C	**February 19-21, 2021**	
Spring A	**March 19-21, 2021**	
Spring B	**April 16-18, 2021**	
Weeklong	**March 14-21, 2021**	

PLEASE NOTE: All payments are due in advance of service.

****For Campers paying with CDC+ APD Funds, or other Third Party Payors – session rates will be billed at the $359 rate for each weekend and $1,179 for weeklong camp at the conclusion of each session the camper attends. If a third party payor has not paid prior to the next session, payment must be made prior to attendance.****
****Separate written authorization is be required for all campers using any Third Party Payors. ****

By signing below I acknowledge:

- **Each session must be paid in full AT LEAST 21 days prior to each session or LATE FEES WILL APPLY.**
- **All camp fees are non-refundable once camper is accepted to any camp program/session(s).**
- **That if camper submits an application along with payment and the camper is deemed ineligible to attend Camp by Easterseals Florida management, the deposit check, and any other funds, will be returned in full.**
- **That if camper fails to complete any camp session, no refund or credit will be given.**
- **That all camp fee payments will be forfeited for campers who fail to attend assigned session(s).**
- **There are no refunds or credits given.**

_____ _____ _____
Signature of Legal Guardian **Printed Name of Legal Guardian** **Date**

_____ _____ _____
Signature of Payor (If different than person above) **Printed Name of Payor** **Date**

Make Checks payable to Easter Seals Florida and mail to:

Easterseals Florida - Camp Challenge
31600 Camp Challenge Road
Sorrento, FL 32776

- -

Or pay by credit card:

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express

Credit Card # _____ v-code# _____ Exp. Date _____/_____

Card Holder Name _____ Signature _____

Credit card information is not stored and will be needed for each payment

Or to pay by phone: Contact the Camp Office at 352.383.4711 Monday to Friday between 9:30 am and 3:30 pm.

MEDICAL AND LIABILITY RELEASE/INSURANCE INFORMATION

THIS FORM **MUST** BE COMPLETED AND SIGNED BY THE **LEGALLY RESPONSIBLE CAMPER OR GUARDIAN**.

Separate medical documentation will be sent in the week prior to each session regarding COVID-19 screening

(Please include a copy of insurance card (front and back) or Medicare/ Medicaid card with this form)

Easter Seals Florida - Camp Challenge carries a limited Camper's Accident and Sickness Insurance Policy covering all campers. Details of this may be obtained by contacting the camp office. Pre-existing conditions are not covered under this policy. All medical expenses not covered under Camp Challenge's Accident and Sickness Policy will be the responsibility of the legal guardian. The following information is required for camp records. Please complete with respect to the hospitalization and/or major medical insurance covering the camper.

Name of Insurance Carrier: _____

Policy Holder: _____

SSN#:_____

Policy Number: _____

Certificate Number: _____

Code or Group Number: _____

Medicare/Medicaid Number:_____

I hereby give permission for _____(camper name) to receive any examinations and any medical or surgical treatment which the camp's nurse, camp's physician, or any other referred physician, dentist or hospital may determine to be advisable during the camper's period of attendance at Camp Challenge.

This health history is current to the best of my knowledge and belief; and the camper herein described has permission to engage in all prescribed activities, except as noted. Reports and records may be requested from or sent to doctors and referring agencies. This form may be photocopied for use outside of Camp.

I am in receipt of the Easter Seals Florida's Notice of Privacy Practices. _____

(Please Initial Here)

I release and completely discharge Easter Seals Florida, Inc., Camp Challenge, its officers and directors, and any persons in privity with any of them, from any and all liability, legal responsibility, claims, damages, or causes of action arising from any and all damage or injury to my person or property, including my death that may occur while on Easter Seals property or being provided services by volunteers or contractors of Easter Seals, and hereby waive all such claims or causes of action. This release, discharge and waiver is intended to apply even to affirmative acts of negligence on the part of the released parties, i.e. Easter Seals Florida, Inc. and/or its representatives, agents, employees, officers, directors, volunteers, consultants or contractors.

If I am injured, I agree not to sue Easter Seals Florida, Inc., Camp Challenge, or any officers, directors, representatives or agents thereof, or start any other type of legal action as a result of any damage or injury I may incur. In the case of my death, I hereby direct my personal representatives, heirs, executors, next-of-kin, or spouse not to sue these parties on behalf of my survivors or my estate.

_____ _____

Signature of Legal Guardian Date

_____ _____

Witness Date

Easterseals Camp Challenge

CAMPER MEDICAL FORM

(To be completed by a Licensed Physician – 2 pages)

NOTE: Due to COVID-19 ALL campers must have this completed by a licensed physician prior to attendance at the first registered session. (Example: a camper attending in October must have their physical prior to October Weekend Camp but a camper attending Spring Weeklong Camp only may wait until March to complete their physical).

Camper's Full Name:_____

Address: _____

DOB: **/ /** ***Age:*** _____ ***Sex:***_____ ***Phone:***

HEALTH EXAMINATION √ = satisfactory X = unsatisfactory (explain) 0 = Not Examined

Height:	**Weight:**

Eyes:	**Lungs:**	**Posture:**	**Sensation:**
Nose:	**Heart:**	**Balance:**	**Circulation:**
Ears:	**Abdomen:**	**Coordination:**	**Nutrition:**
Teeth:	**Skin:**	**Spasticity:**	**Hernia:**
Throat:	**Extremities:**	**Motion Limits:**	**Genitalia:**

Applicant's primary disability (Medical Diagnosis): _____

Secondary disability (if any): _____

Applicant is under the care of a physician for the following condition(s):_____

_____

Current Treatments: _____

IMMUNIZATION HISTORY

Does the camper have all the recommended vaccines? Yes [ ] No [ ] **Date of last Tetanus: _____**

If no, explain_____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP:

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

CURRENT OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP: (Vitamins, OTC Allergy Medication, etc.)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

*****NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order*****

Physician's Signature: _____ **Date:** _____

Camp Challenge medical staff routinely administer the following over-the counter medications. Please check all medications that may be given to the camper on an as-needed basis.

☐ **Camper may have ALL of the medications listed below**

☐ Acetaminophen 325mg	☐ Ibuprofen	☐ Barrier Cream (Zinc Oxide)	☐ Eye Drops (Visine)
☐ Diphenhydramine HCL	☐ Glycerin Suppository	☐ Antacid (Tums)	☐ Pepto Bismal
☐ Hydrocortisone Cream	☐ Triple Antibiotic Cream	☐ Aloe	☐ Nasal Decongestant
☐ Cold and Allergy Medicine	☐ Unisom (Sleep Aid)	☐ Bacitracin Ointment	

ALLERGIES (Food, Medication, Plants, Insects) _____

Reaction Type

☐ Anaphylaxis ☐ Rash/Hives ☐ Upset Stomach ☐ Other: _____

DIETARY RESTRICTIONS **Yes [ ] No [ ]**

If yes, explain:

_____

_____

SEIZURES: **Yes [ ] No [ ]** Type _____ Date of last seizure: _____

Known Seizure Triggers: _____ Medication Controlled? Yes [ ] No [ ]

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

_____

_____

_____

_____

Can the camper be outside for approximately 1 hour at a time? ☐ Yes ☐ No

Can the camper safely sleep overnight in a cabin environment? ☐ Yes ☐ No

Is the camper at excessive risk for dehydration? ☐ Yes ☐ No

Bowel Habits: Frequency? _____ Preventive medications (e.g.: Miralax)? _____

Comments:

_____

_____

PHYSICIANS STATEMENT

I have examined the camp applicant. In my opinion, the camper's disability or health condition:

Allows [ ] Does Not Allow [ ] his/her participation in an active camp program. The camper is specifically able to participate in the following activities:

[ ] Swimming

[ ] Outdoor Activities lasting 45-60 minutes

_____ _____

Licensed Physician's Signature Physician Name (printed)

_____

Date of Most Recent Examination

Physician Address:_____

City_____ State _____ Zip Code _____

Phone: ( ) _____

CAMPER/LEGAL GUARDIAN COPY-DO NOT RETURN WITH PACKET

EASTER SEALS FLORIDA

NOTICE OF PRIVACY PRACTICES

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

This Notice is effective as of April 14, 2003.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in lobby, reception area and on our web site. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Rikesha Blake. You can contact the Privacy Officer at 407-306-9766.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the **Secretary of the Department of Health and Human Services** about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are <u>required</u> to make without your permission

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are <u>allowed</u> to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

We may use or disclose information from your record for research under certain conditions.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

We may contact you for fundraising efforts.