ATTENTION

If you have already enrolled your student in North Country Family Health Center's School-Based Health Center services for this school year using our on-line platform or a paper enrollment form, you do NOT have to complete the attached paperwork. If you have not yet enrolled your student in our School-Based Health Center medical, dental, or counseling services please complete the enclosed packet and return it to school. Any student is eligible to enroll in our services, even if he or she already has a primary care provider or dentist.

N★Co Family Health

Completion of Enrollment Form
is ***Required*** Each Year

Today's Date:

School-Based Health Center (SBHC)
2021-2022 Enrollment Form

Student Information

Medical/Dental School-Based Health Center Enrollment:

What Services do You Want to Enroll Your Student in: ☐ Medical ☐ Dental ☐ Counseling Services

Student Information:

First Name:	Last Name:	Full Middle Name:
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Biological Mother's Maiden Name:
Street Address		
Student's School:	Grade	Teacher/Homeroom:

Student's Primary Care Provider: ☐ My Student Doesn't Have a Regular Doctor	Student's Dentist: ☐ My Student Doesn't Have a Regular Dentist

Preferred Pharmacy & Location:

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

Race (please select): ☐ White ☐ Black or African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unreported/Decline to Report	Ethnicity (please select): ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Preferred Language (student speaks): ☐ English ☐ Spanish ☐ Mandarin Chinese ☐ Sign Language ☐ Other:_____ Translation Assistance Needed: ☐ Yes ☐ No

Where did the Student Sleep Last Night:
☐ At Home/Apartment ☐ Shelter ☐ Car/RV ☐ Street ☐ Do Not Have a Place ☐ With a Friend/Relative

Household Size & Income: Number of People in the Household: _____Income $_____☐Week ☐Month ☐Year

Parent /Guardian Information

Parent/Guardian Information:

Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian – (please provide a copy of court order) ☐ Other:	Relationship to Student: ☐ Father ☐ Mother ☐ Step Parent ☐ Guardian – (please provide a copy of court order) ☐ Other:
Mailing Address:	Mailing Address:
Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to leave a message: ☐ Yes ☐ No	Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to leave a message: ☐ Yes ☐ No
Email: Okay to Email for Non-Emergent Situations: ☐ Yes ☐ No	Email: Okay to Email for Non-Emergent Situations: ☐ Yes ☐ No
Employer:	Employer:
Work Phone:	Work Phone:
Date of Birth:	Date of Birth:

Who Does the Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Other:

Who Will make Healthcare Decisions for This Student: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Other:

Do we have permission to call the student's emergency contact you provided to the school: ☐ Yes ☐ No

Student Name: _____ Date of Birth: _____

Insurance/Guarantor Information

Responsible Person Information - Person Who is Responsible for Payment of the Student's Account:		
First Name:	Middle:	Last Name:
Date of Birth: ☐ Listed above	Social Security #:	Phone: ☐ Cell ☐ Home ☐ listed above
Address of Person Responsible: ☐ Listed above		
City/State/Zip: ☐ Listed above	Relationship to Student: ☐ Self ☐ Parent ☐ Guardian* ☐ Custodial Parent* ☐ Foster Parent* *Proof of legal status required	

Primary Medical Insurance	**Dental Insurance**
Please Attach a Copy of Your Insurance Card(s)	
☐ The Student ***Has*** Medical Insurance ☐ The Student ***Does Not*** have ***Medical*** Insurance Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.	☐ The Student ***Has Dental*** Insurance ☐ The Student ***Does Not*** have ***Dental*** Insurance Contact our Certified Application Counselor at 315-782-9450 x 8038 to help enroll your student in a healthcare plan that is right for you and your family.
Insurance Company Name:	Insurance Company Name:
Medical Policy #:	Dental Policy #:
Billing Address of Insurance Co:	Billing Address of Insurance Co:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
☐ I have additional ***Medical*** Insurance (name of insurance co.):	☐ I have additional ***Dental*** Insurance (name of insurance co.):

North Country Family Health Center Policies and Consents

Consent for School-Based Health Medical, Dental and Counseling Services 2021-2022

I authorize my 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 NCFHC School-Based Health Center. Services may include, but are not limited to: comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and counseling services, if needed. I consent to photographs being taken of the student for inclusion in their confidential electronic medical record for diagnosis and treatment only. 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 understand that every effort will be made to contact me prior to treatment, however I understand this may not always be possible. 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.

North Country Family Health Center Policies and Consents

Permission to Disclose to Family or Other Individuals

Pediatric Consent

Non-Parental Consent: For pediatric patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions.

☐ **No**, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

☐ **Yes**, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for medical/dental/behavioral healthcare and to make treatment decisions for my child in my absence. I understand that when I designate

Student Name: _____ Date of Birth: _____

another person to authorize a treatment decision, North Country Family Health Center may disclose protected health information to the authorized person(s). This consent is valid for one year from date of signature unless revoked in writing prior to expiration.

Name of Individual(s):	Relationship to Student:

Finance Policy:

North Country Family Health Center's (NCFHC) School-Based Health Program serves all students 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.

I 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. As applicable, I authorize my insurance provider to pay North Country Family Health Center, Inc. for services rendered.

Notice of Privacy Practices:

- I have been given the opportunity to review or receive a copy of North Country Family Health Center's (NCFHC) Notice of Privacy Practices which describes how NCFHC may use and disclose my student's protected health information following applicable state and federal law.
- I understand that this may include disclosures of information to my student's insurance carrier(s) to issue payment directly to NCFHC.
- I understand that I have the right to receive a copy of my student's medical information or to request restrictions on the use of my student's protected health information.
- I understand that NCFHC may engage business associates to assist in my student's coordination of care including afterhours telephone coverage and call reminder service.
- I understand any reminder calls, texts, or email correspondence may be recorded to improve customer service and patient care.

Telehealth:

- NCFHC offers its patients telehealth services as a method to expand access to care. I understand my student may be offered a telehealth appointment at NCFHC.
- I consent for my student to receive services via North Country Family Health Center's (NCFHC) telehealth equipment and understand and/or agree to the following:
- I understand my student has the right to refuse to participate in services delivered via telehealth at any time by informing any NCFHC staff member.
- I may request at any time for an in-person appointment with another NCFHC healthcare provider.
- I understand that by selecting another provider there could be a delay in service and the potential need to travel for a face-to-face visit.
- I understand there are potential drawbacks of participating in a telehealth visit versus a face to face visit.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my student's care and treatment require physical examination that may be conducted by other NCFHC providers and staff under the direction of my student's telehealth healthcare provider or my student may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand my student's visit will be conducted via technology and NCFHC cannot guarantee technology will always work.
- I understand that if there is an equipment failure my student may need to be rescheduled for a face-to-face visit.
- I understand NCFHC utilizes HIPAA compliant, encrypted software to conduct its telehealth services.
- I understand my student has the right to ask any questions regarding the telehealth equipment, technology, etc. at any time.
- I understand my student will be informed and made aware of: the role of the telehealth provider at the distant site, as well as qualified professional staff at the NCFHC location who are going to be responsible for follow-up or ongoing care; and the location of the distant site.

Student Name: _____ Date of Birth: _____

- I understand my student has the right to have appropriately trained staff immediately available to me while receiving the telehealth service to attend to emergencies or other needs. I understand this is not possible if conducting a telehealth visit from my place of residence located within the state of New York or other temporary location within or outside the state of New York.
- I understand my student has the right to be informed of all parties who will be present at each end of the telehealth transmission; and consent to have NCFHC staff in the exam room to operate telehealth equipment, if needed.

My Signature Means:

I have reviewed and completed the Consent for School-Based Health Medical, Dental and Counseling Services and Permission to Disclose to Family or Other Individuals sections. I understand that when I designate another person to authorize a treatment decision, North Country Family Health Center may disclose protected health information to the authorized person(s).

I have reviewed North Country Family Health Center's Finance Policy, Consent for Treatment, Notice of Privacy Practices, and Telehealth Policy.

I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.

I understand that my consent 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.

Printed Name of Legally Authorized Representative:	State Relationship to Student:

Signature of Legally Authorized Representative:

Date:

Student Name: _____ Date of Birth: _____

Medical/Dental History Form:

Has your student had any history of/or conditions related to any of the following:
☐ ADHD/Mental Health Issues ☐ Asthma ☐ Autism ☐ Cancer ☐ Cardiac Issues ☐ Chicken Pox ☐ Diabetes
☐ Growth Problems ☐ Kidney/Urinary Issues ☐ Latex Allergy ☐ Rheumatic Fever ☐ Seizures ☐ Thyroid Issues
☐ Tuberculosis ☐ Other:

Last Physical Exam was on (provide date):

Past Surgeries: ☐ No ☐ Yes (please list):

Past Hospitalizations: ☐ No ☐ Yes (please list):

Does the Student See a Healthcare Specialist: ☐ No ☐ Yes (name & phone #):

Allergies: ☐ No ☐ Yes (please list what allergen and reaction to each item):

Daily Medications: ☐ No ☐ Yes (please list):

Has the student or anyone who lives in your house ever been exposed to or had contact with anyone with a positive tuberculosis screen or active tuberculosis disease: ☐ No ☐ Yes (please list name):

Does the student have developmental delays or problems? ☐ No ☐ Yes (please list):

Does the student have any current dental problems? ☐ No ☐ Yes (please list):

Has the student had problems with dental treatment in the past? ☐ No ☐ Yes (please explain)

How many individuals smoke in the house:

Has the student had any injury to the mouth or teeth? ☐ No ☐ Yes (please explain):

What type of water does the student drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water

Family History:
Check any of the following conditions a relative has had, please include both mother's and father's side of the family:

	Mom	Dad	Sister Brother	Aunt Uncle	G-Parent		Mom	Dad	Sister Brother	Aunt Uncle	G-Parent
Allergies/eczema						Migraines					
Asthma						Obesity					
Cancer						Stomach/GI Issues					
Diabetes						Stroke					
High Blood Pressure						History Unknown					
Kidney Disease						Other:					
Mental Health Issues											

North Country
Family Health Center, Inc

*****ONLY COMPLETE THIS FORM IF YOU WANT YOUR STUDENT TO RECEIVE COUNSELING SERVICES BY A LICENSED SOCIAL WORKER IN THE 2021-2022 SCHOOL YEAR*****

REQUEST FOR SCHOOL-BASED COUNSELING SERVICES

Date of Request: Name of School: Grade:

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):

FULL NAME:	*AGE/GENDER	FULL NAME:	*AGE/GENDER
_____	_____ ___	_____	_____ ___
_____	_____ ___	_____	_____ ___
_____	_____ ___	_____	_____ ___
_____	_____ ___	_____	_____ ___
*(A=Adult)		*(A=Adult)	

PART II. REASON FOR REQUEST

Does your child currently see a licensed Mental Health Therapist outside of school?

Are you concerned about your child's attitude or behaviors? (please explain)

Do you have concerns with your child at school?
____Poor Academics
____Suspensions/Detentions
_____Attention concerns

Comments:

Does your child get IEP counseling provided by the school?

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

9/29/2021ALF

North Country Family Health Center, Inc

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****

Student's Name:	Student's Date of Birth:	Student's SS#:
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:	Relationship to the Student:
Signature of Authorized Person:	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****

Student's Dentist'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 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:	Relationship to the Student:
Signature of Authorized Person:	Date:

North Country Family Health Center

School-Based Health Center Transportation Consent, Waiver, and Release Form

The South Jefferson Central School District and the North Country Family Health Center (NCFHC) collaborate to offer K-12 students medical, counseling, and dental care in their comprehensive School-Based Health Centers (SBHCs) which are located at the Mannsville and Wilson Elementary buildings.

NCFHC will provide transportation for Clarke students to attend medical, dental, and counseling appointments at the Mannsville and Wilson SBHCs, when school is in session. Transportation will be provided by a NCFHC employee using a NCFHC vehicle on an as needed basis by appointment only. A transportation consent, waiver, and release form must be on file in order for NCFHC to provide transportation services to students enrolled in our services.

When a Clarke student must travel to an appointment at the Wilson or Mannsville Elementary SBHC, the NCFHC Transportation Coordinator will meet students in the Clarke Attendance Office. Students will sign themselves out of the Clarke building and will walk out to the NCFHC transportation vehicle with the NCFHC Transportation Coordinator. Once at the Mannsville or Wilson SBHC, the Transportation Coordinator will walk students into the SBHC for their appointment. Once back at Clarke, the Transportation Coordinator will walk students back to the Attendance Office. The student will then sign back in and return to class.

TRANSPORTATION SERVICES CONSENT, WAIVER, AND RELEASE FORM

Note: Please read this form carefully and in its entirely before signing, and be aware that, in consideration of North Country Family Health Center (NCFHC)'s School-Based Health Center (SBHC) Transportation Services, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages, or loss which your child may sustain as a result of the provided transportation.

I, the undersigned, give my consent for my child to be transported by NCFHC for the 2021-2022 school year in connection with non-emergency medical services, and will assume all liability for my own, and everyone in my travelling party as identified below, participation in these transportation services. I understand that transportation is only provided on days when school is in session and is by appointment only.

Further, by signing below I acknowledge that I have read, recognize, acknowledge, and agree that:

1. I, and everyone in my traveling party recognize and acknowledge that NCFHC is neither a common carrier, nor in the business of providing transportation services to the public, and that there are certain inherent risks of physical injury to vehicle passengers in the course of transportation. Further, I, and everyone in my traveling party, knowingly, willingly, and voluntarily agree to assume any and all risks associated receiving transportation services offered NCFHC, including but not limited to personal injury, illness, accidents, property loss, damages, and any other loss arising out of negligent operation or supervision of the vehicle.
2. I, and everyone in my travelling party, will not hold NCFHC, its officers, agents, employees, assigns, or anyone acting on its behalf, responsible or liable for injury occurring to myself, my child, or anyone in my traveling party in the course of such transportation services.
3. I, and everyone in my traveling party, further agree to waive and release all claims we may have, or which may accrue against us, against NCFHC, including its respective officials, agents, volunteers, and employees. Further, I and everyone in my traveling party, do hereby fully release and forever discharge

NCFHC from any and all claims for injuries, damages, or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

4. I, and everyone in my traveling party, agree to refrain from eating, drinking, and smoking in the course of transportation services offered by NCFHC.
5. I, and everyone in my traveling party, further agree that this agreement shall be governed by the laws of the State of New York.
6. I, and everyone in my traveling party, further agree, due to the health and safety concerns surrounding the coronavirus, to wear a face covering at all times during transport by NCFHC.

This Consent, Waiver, and Release will be valid for all transportation occurring as of and after this date below. This Consent, Waiver, and Release is valid for a period of one year.

You MUST complete the information below for EACH student.

Student's Information:		
First Name:	Middle Name:	Last Name:
Grade:	Homeroom Teacher:	

_____

Parent/Guardian's Name

_____ _____

Parent/Guardian's Signature Date

North Country Family Health Center

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

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 HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections 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 HealtheConnections 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.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

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

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections 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 HealtheConnections. 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	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	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 HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.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 HealtheConnections 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 HealtheConnections website at http://healtheconnections.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 HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections 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 HealtheConnections 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**.**