

## 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.







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

Today's Date:

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

<b>Medical/Dental School-Based Health Center Enrollment:</b>		
What Services do You Want to Enroll Your Student in: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Counseling Services		
<b>Student Information:</b>		
First Name:	Last Name:	Full Middle Name:
Date of Birth:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Biological Mother's Maiden Name:
Street Address		
Student's School:	Grade	Teacher/Homeroom:
Student's Primary Care Provider: <input type="checkbox"/> My Student Doesn't Have a Regular Doctor		Student's Dentist: <input type="checkbox"/> My Student Doesn't Have a Regular Dentist
Preferred Pharmacy & Location:		
<b>North Country Family Health Center, as a Federally Qualified Health Center, <i>MUST</i> ask you to complete the following questions:</b>		
Race (please select): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/Decline to Report		Ethnicity (please select): <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino
Preferred Language (student speaks): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Mandarin Chinese <input type="checkbox"/> Sign Language <input type="checkbox"/> Other: _____ Translation Assistance Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Where did the Student Sleep Last Night: <input type="checkbox"/> At Home/Apartment <input type="checkbox"/> Shelter <input type="checkbox"/> Car/RV <input type="checkbox"/> Street <input type="checkbox"/> Do Not Have a Place <input type="checkbox"/> With a Friend/Relative		
Household Size & Income: Number of People in the Household: _____ Income \$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		
<b>Parent/Guardian Information:</b>		
Name:	Name:	
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:	Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step Parent <input type="checkbox"/> Guardian – (please provide a copy of court order) <input type="checkbox"/> Other:	
Mailing Address:	Mailing Address:	
Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to leave a message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email: Okay to Email for Non-Emergent Situations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Email: Okay to Email for Non-Emergent Situations: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer:	Employer:	
Work Phone:	Work Phone:	
Date of Birth:	Date of Birth:	
Who Does the Student Live With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Who Will make Healthcare Decisions for This Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Do we have permission to call the student's emergency contact you provided to the school: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Responsible Person Information - Person Who is Responsible for Payment of the Student's Account:		
First Name:	Middle:	Last Name:
Date of Birth: <input type="checkbox"/> Listed above	Social Security #:	Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> listed above
Address of Person Responsible: <input type="checkbox"/> Listed above		
City/State/Zip: <input type="checkbox"/> Listed above	Relationship to Student: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian* <input type="checkbox"/> Custodial Parent* <input type="checkbox"/> Foster Parent* *Proof of legal status required	
Primary Medical Insurance	Dental Insurance	
Please Attach a Copy of Your Insurance Card(s)		
<input type="checkbox"/> The Student <b>Has</b> Medical Insurance <input type="checkbox"/> The Student <b>Does Not</b> have <b>Medical</b> 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.	<input type="checkbox"/> The Student <b>Has Dental</b> Insurance <input type="checkbox"/> The Student <b>Does Not</b> have <b>Dental</b> 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 #:	
<input type="checkbox"/> I have additional <b>Medical</b> Insurance (name of insurance co.):	<input type="checkbox"/> I have additional <b>Dental</b> 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											





**\*\*\*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: _____	
<b>PART I. FAMILY INFORMATION</b>	
Child/Adolescent being referred (full name): _____ DOB: _____	
Parent/Guardian(s) requesting counseling services: _____	
Relationship to child: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> 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)
<b>PART II. REASON FOR REQUEST</b>	Do you have concerns with your child at school?
Does your child currently see a licensed Mental Health Therapist outside of school?	<input type="checkbox"/> Poor Academics
Are you concerned about your child's attitude or behaviors? (please explain)	<input type="checkbox"/> Suspensions/Detentions
	<input type="checkbox"/> Attention concerns
	Comments:
	Does your child get IEP counseling provided by the school?
<b>PART III. OTHER INFORMATION</b>	Date of Last Physical Exam: _____
Insurance:	Name of Student's Primary Care
<input type="checkbox"/> Medicaid	Provider: _____
<input type="checkbox"/> CHP	
<input type="checkbox"/> Other _____	
<b>PART IV. SIGNATURES</b>	
I have received the letter describing the mental health referral process and a copy of the community resource list. <u>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.</u>	
_____	_____
Parent/Guardian Signature	Date





**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\*\***

<b>Student's Name:</b>	<b>Student's Date of Birth:</b>	<b>Student's SS#:</b>
<b>Student's Address:</b>		
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.		
<b>Student's Primary Care Provider's Name:</b>		
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.		
<b>Type of Information to be Released (check all that apply):</b>		
<input type="checkbox"/> Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues. <input type="checkbox"/> Clinical records of mental health treatment <input type="checkbox"/> HIV/AIDS-related information <input type="checkbox"/> Records from alcohol/drug treatment programs		
Unless previously revoked by me in writing, this release is effective from <u>the date below to one year after signing.</u>		
<b>Name of Authorized Person Signing the Form:</b>	<b>Relationship to the Student:</b>	
<b>Signature of Authorized Person:</b>	<b>Date:</b>	

**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\*\***

<b>Student's Dentist's Name:</b>	
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 <u>the date below to one year after signing.</u>	
<b>Name of Authorized Person Signing the Form:</b>	<b>Relationship to the Student:</b>
<b>Signature of Authorized Person:</b>	<b>Date:</b>



## ***School-Based Health Center Transportation Plan & Consent***

The Watertown City School District (WCSD) will provide transportation for students to and from appointments with North Country Family Health Center when school is in session. Transportation will be provided from 8:30 am to 12:00 pm. **A parent permission form must be on file in order for WCSD to provide transportation.**

When students in grades K-4 have an appointment (scheduled), the transportation provider will go into the school to pick the child up and bring the student to the bus. He/She will transport the student to the appointment, walking him/her into the clinic. Either he will escort the student back to the bus or someone from the clinic will do so. Once the bus has returned the student to the school where he/she attends, the transportation provider will escort the student to the Main Office of that school building.

When a student in grades 5-12 must travel to an appointment outside of their building but still on the main campus, students will sign out of the building and walk to the building on campus (Wiley, Case, or WHS) where they have their appointment. Upon returning to their building of attendance, they will sign back in. Parent permission must be on file for students to walk from one building to another on the main campus. In the event that students in grades 5-12 have an appointment (scheduled) and must travel off the main campus for the appointment, the transportation provider will wait in front of the school to pick up the student. He will transport the student to the appointment, walking him/her into the clinic. Either he will escort the student back to the bus or someone from the clinic will do so. The bus will drop off the student at the main entrance of the school in which he or she is in attendance. It will be the student's responsibility to check in at the Main Office of Wiley Intermediate School, Case Middle School or Watertown High School.

The Watertown City School District and the North Country Family Health Center collaborate to offer K-12 students health and dental care. The district is able to provide transportation, mornings only, on an as needed basis, to and from any appointments; they may have with the health center clinics. If you wish to approve your child receiving transportation to and from these appointments (when scheduled during days school is in session), **YOU MUST complete the information below.**

For the 2021-2022 school year, I authorize the Watertown City School District to provide my child with transportation to and from any appointments; they may have with the North Country Family Health Center. I understand that transportation is only provided on days when school is in session and during morning hours as applicable. If my child is a Watertown High School or Case Middle School student, I authorize him/her to walk from the respective building to Wiley Intermediate School for any appointments and back, signing in and out of the building as required by administration. If my child is a Knickerbocker, Starbuck, Sherman, or Ohio Street student who needs services, they will be provided transportation to North Elementary school for services.

**Student's Name:**

**Grade:**

**Teacher:**

**Parent's Name:**

**Parent 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 HealthConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealthConnections 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 HealthConnections website at <http://healthconnections.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.**

<p><b>My Consent Choice.</b> 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.</p>
<p><input type="checkbox"/> <b>1. I GIVE CONSENT</b> for the Organization named above to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> <b>2. I DENY CONSENT</b> for the Organization named above to access my electronic health information through HealthConnections for any purpose, <i>even in a medical emergency</i>.</p>

If I want to deny consent for all Provider Organizations and Health Plans participating in HealthConnections to access my electronic health information through HealthConnections, I may do so by visiting HealthConnections website at <http://healthconnections.org/> or calling HealthConnections 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 Health<sub>e</sub>Connections 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 Health<sub>e</sub>Connections. 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 Health<sub>e</sub>Connections. You can obtain an updated list at any time by checking Health<sub>e</sub>Connections website at <http://healthconnections.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 Health<sub>e</sub>Connections 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 Health<sub>e</sub>Connections website at <http://healthconnections.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 Health<sub>e</sub>Connections ceases operation (or until 50 years after your death, whichever occurs first). If Health<sub>e</sub>Connections 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 Health<sub>e</sub>Connections 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.