North Country Family Health Center

Patient Registration Form

Patient Information

Patient Information:

First Name:	Last Name: M.I.:	First Name Used:
Street Address: Apt # City: State: Zip:		
Mailing Address: ☐ Same as Street Address		
Home Phone: ☐ None	Cell Phone: ☐ Cell Phone is Home Phone	Work Phone:

Social Security #:	Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Legal Sex: ☐ Male ☐ Female	Occupation:

Employment Status: ☐ Student ☐ Employed ☐ Retired ☐ Unemployed	Employer **or** School District for Student:	Employer or School District Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	Mother's Maiden Name:

Emergency Contact Name:	Emergency Contact Phone #:	Relationship to Patient:

Guardian or Foster Parent Name: ☐ N/A	Foster Parent Agency: ☐ N/A

Additional Information

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:	Preferred Pharmacy & Location:

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

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

Household Size & Income: *For children enter family information*
Number of People in the Household: _____ Income $_____ ☐ Week ☐ Month ☐ Year

Housing Status of Patient: (Location Patient Slept Last Night)
☐ At Home/Apartment/Group Home ☐ Shelter ☐ Car ☐ Street ☐ With a Friend/Relative

Migratory/Seasonal Agricultural Work Status of Patient: (Patient is, OR is a Dependent of, a Seasonal or Migratory Worker)
☐ No ☐ Yes - Migrant ☐ Yes - Seasonal ☐ Yes - Retired Migrant/Seasonal Agricultural Worker

Other

Complete Only if the Patient is 18 Years or Older

What Gender Do You Identify as (please select):
☐ Male ☐ Female ☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male) ☐ Choose Not to Disclose

Sexual Preference/What Do You Think of Yourself as (please select):
☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Pronouns Preferred: ☐ He/Him ☐ She/Her ☐ They/Them	Are You a Veteran (please select): ☐ Yes ☐ No

Patient Name: _____ Date of Birth: _____

Insurance Information

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

Primary Medical Insurance	**Dental Insurance**
☐ I ***Do Not*** Have ***Medical*** Insurance ☐ I Would Like to Apply for a ***Reduced Fee*** ☐ I ***Have Medical*** Insurance	☐ I ***Do Not*** Have ***Dental*** Insurance ☐ I Would Like to Apply for a ***Reduced Fee*** ☐ I ***Have Dental*** Insurance
Insurance Company Name:	Insurance Company Name:
Medical Policy #:	Dental Policy #:
Billing Address of Insurance Company:	Billing Address of Insurance Company:
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	☐ I have additional ***Dental*** Insurance
Name of Insurance Company:	Name of Insurance Company:

Patient Rights and Advance Directives

Patient Bill of Rights

Would you like a copy of the Patient Bill of Rights:

☐ Yes, and a copy has been provided to me.

☐ No, but I have been offered printed information and I have had the opportunity to ask questions.

Health Care Proxy

A Health Care Proxy gives someone else the power to make medical decisions for you when you cannot speak for yourself.

Do you have a Health Care Proxy?

☐ Yes, and a copy has been provided to North Country Family Health Center.

☐ Yes, but a copy is not available at this time.

☐ No, but I have been offered printed information related to a Health Care Proxy and I have had the opportunity to ask questions.

Advance Directives

Advance Directives are written instructions relating to how healthcare is to be provided when and if an adult is unable to make their own decisions (examples of an Advance Directive: MOLST, DNR, Living Will, and/or Medical Power of Attorney).

Do you have an Advance Directive?

☐ Yes, and a copy has been provided to North Country Family Health Center.

☐ Yes, but a copy is not available at this time.

☐ No, but I have been offered printed information related to Advance Directives and I have had the opportunity to ask questions.

Patient Name: _____ Date of Birth: _____

North Country Family Health Center Policies and Consents

Permission to Disclose to Family or Other Individuals

Adult Consent (Age 18 and Older)

You may authorize North Country Family Health Center (NCFHC) to disclose your protected health information to family members or other individuals in order to assist with the coordination of your care.

☐ **No**, I do not give NCFHC permission to disclose my protected health information to family members or other individuals in order to assist with the coordination of my care.

☐ **Yes**, I give NCFHC permission to disclose my protected health information to the family members or other individuals listed below in order to assist with my coordination of care. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to the expiration.

OR

Pediatric Consent (Age 17 or Younger)

Non-Parental Consent: For pediatric patients, age 17 and under, 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 another person to authorize a treatment decision, NCFHC may disclose protected health information to the authorized person(s).

Name of Individual(s):	Relationship to Patient:

Finance Policy/Release of Billing Information/Assignment of Benefits:

NCFHC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance: You are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles, or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. If you do not have insurance: We offer a sliding fee scale based on household size and income. You may apply for a discount at the front desk. We can also assist you with obtaining insurance coverage. I authorize NCFHC and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay NCFHC for services rendered.

Consent for Treatment:

- I authorize NCFHC to conduct any diagnostic or routine examinations, tests, and procedures to obtain specimens and to provide any medications, treatment, or therapy as necessary now or at future visits.
- I understand that specimens may be sent to an outside facility for processing. There may be a separate charge for this service.

Privacy Notice:

- I have been given the opportunity to review or receive a copy of NCFHC's Notice of Privacy Practices which describes how NCFHC may use and disclose my protected health information following applicable state and federal law. I understand NCFHC can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.
- I understand that I have the right to receive a copy of my medical information or to request restrictions on the use of my protected health information.
- I understand that NCFHC may engage business associates to assist in my coordination of care including afterhours telephone coverage and call reminder service. I understand these calls may be recorded to improve customer service and patient care.
- I understand NCFHC may use letters, reminder calls, texts, or secure email correspondences to communicate with me regarding my care. I authorize NCFHC to communicate with me via these methods.

Telehealth:

NCFHC offers its patients telehealth services as a method to expand access to care. I understand I may be offered a telehealth appointment at NCFHC. I consent to receive services via NCFHC's telehealth equipment and understand and/or agree to the following:

- I understand I have 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.

Patient Name: _____ Date of Birth: _____

- 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 care and treatment require physical examination they may be conducted by other NCFHC providers and staff under the direction of my telehealth healthcare provider or I 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 visit will be conducted via technology and NCFHC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I 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 I have the right to ask any questions regarding the telehealth equipment, technology, etc. at any time.
- I understand I 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.
- I understand I have 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 I have 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.

New York State Immunization Information System (NYSIIS) Consent:

- I authorize NCFHC to release my immunization(s) and identifying information to NYSIIS, participation in NYSIIS for people 19 years of age and older is voluntary.
- I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future.
- I understand my immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.
- I understand the immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

My Signature Means:

- *I have reviewed and completed the Permission to Disclose to Family or Other Individuals section. 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/Release of Billing Information/Assignment of Benefits; Consent for Treatment; Privacy Notice; Telehealth Policy; and NYSIIS Consent.*
- *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 for one year, unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.*

Printed Name of Patient/Legally Authorized Representative:	Relationship to Patient: ☐ Patient ☐ Relationship to Patient:_____
Signature of Patient or Legally Authorized Representative:	Date:
Witness to Signature if Legally Authorized Representative:	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**.**

North Country Family Health Center

2023 Sliding Fee Discount Program Application

I am applying for a **Discounted Fee** for ☐ **Medical Care** ☐ **Dental Care** ☐ **Both**

Individual Applying for Discounted Fee (Indicate household members to be included in this application below)			**Date: / /**
First Name:	Middle:	Last:	Date of Birth: / /
Home Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Home Phone #: ( ) -	Cell Phone #: ( ) -		
Social Security # - -	Do you have insurance? ☐No ☐Yes If yes, name of insurance company:		
Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

OTHER PEOPLE in your household:

Name	Date of Birth	Social Security Number	Applying for Discounted Fee?
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No
	/ /	- -	☐ Yes ☐ No

To comply with federal regulations, in order to give you a discount on our services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence. You must verify your income at least every year.

Employment Income

Name	Amount	How Often?	Employer:
You	$	☐ Week ☐ Month ☐ Year	
Spouse	$	☐ Week ☐ Month ☐ Year	
Children	$	☐ Week ☐ Month ☐ Year	
Other	$	☐ Week ☐ Month ☐ Year	
TOTAL	$	☐ Week ☐ Month ☐ Year	

Other Income

	You	Spouse	Children	Other	How Often?
Social Security	$	$	$	$	☐ Week ☐ Month ☐ Year
Public Assistance	$	$	$	$	☐ Week ☐ Month ☐ Year
Retirement Pension	$	$	$	$	☐ Week ☐ Month ☐ Year
Disability	$	$	$	$	☐ Week ☐ Month ☐ Year
Child Support/Alimony	$	$	$	$	☐ Week ☐ Month ☐ Year
Other	$	$	$	$	☐ Week ☐ Month ☐ Year

For Office Use Only:

☐ Approved ☐ Denied

Household Size: _____

Total Gross Income:

_____

MEDICAL	DENTAL
☐ A	☐ A
☐ B	☐ B
☐ C	☐ C
☐ D	☐ D
☐ E	☐ E

Approval Signature:

_____

Date: _____

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform North Country Family Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of North Country Family Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____ Name (Please Print): _____

Signature: _____

Your application is considered PENDING until you receive written approval from North Country Family Health Center, Inc.

01/2023 JLA

North Country Family Health Center

2023 Sliding Fee Discount Program Information

We will ask you to update your Sliding Fee Discount Program Application every 12 months.

*****This program is only valid at North Country Family Health Center locations*****

As a Federally Qualified Health Center it is our mission is to make sure patients can afford the healthcare they need. That is why we offer qualified patients a **Sliding Fee Discount.**

- Our sliding fee discount is for anyone whose household income is at or below **200% of the Federal Poverty Guidelines.** "Household" includes all people living in the same house or apartment that the primary applicant is financially responsible for.
- After you fill out the Sliding Fee Scale Application, we can tell you how much we can discount your fee. We can use this discount for any amount due and for any services we offer.
- It can take up to two weeks to process completed applications. Your application is considered **PENDING** until you receive written notice that it has been approved.
- ***We will give you the care you need no matter what you can pay***.

How to apply for our sliding fee discount:

Our front desk staff can help you apply. Asking about your household size and income is always done as part of check-in.

To apply for a discount, you must fill out a short form and show us proof of income. If you don't have proof of income on your first visit, we can give you 30 days to bring in one of the documents listed below. Your application can't be approved until we have all the paperwork we need.

What you need to bring for "proof of income":

The following will be accepted as proof of income (**more than one document may be required**):

- A copy of your 2022 tax return
- A copy of your 2022 W-2 (If you did not file a return)
- Pay stubs from last 30 days (4 consecutive weekly or 2 consecutive biweekly)
- Written statement from your employer on their letterhead
- 2023 Social Security Benefits Statement
- Proof of Unemployment income (Determination Letter)
- Proof of Disability income
- Proof of other income (if you have it) like child support, alimony, or pension

****Please note we are unable to accept bank statements as proof of income****

2023 Sliding Fee Schedule
(Based Upon 2023 HHS Federal Poverty Guidelines Effective 01.12.2023)

	ANNUAL GROSS INCOME											
Percentage of Federal Poverty Guidelines	0% -	100%	101% -	125%	126% -	150%	151% -	175%	176% -	200%	Over 200%	Over 200%
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$14,580	$14,581	$18,225	$18,226	$21,870	$21,871	$25,515	$25,516	$29,160	$29,161	and over
2	$0	$19,720	$19,721	$24,650	$24,651	$29,580	$29,581	$34,510	$34,511	$39,440	$39,441	and over
3	$0	$24,860	$24,861	$31,075	$31,076	$37,290	$37,291	$43,505	$43,506	$49,720	$49,721	and over
4	$0	$30,000	$30,001	$37,500	$37,501	$45,000	$45,001	$52,500	$52,501	$60,000	$60,001	and over
5	$0	$35,140	$35,141	$43,925	$43,926	$52,710	$52,711	$61,495	$61,496	$70,280	$70,281	and over
6	$0	$40,280	$40,281	$50,350	$50,351	$60,420	$60,421	$70,490	$70,491	$80,560	$80,561	and over
7	$0	$45,420	$45,421	$56,775	$56,776	$68,130	$68,131	$79,485	$79,486	$90,840	$90,841	and over
8	$0	$50,560	$50,561	$63,200	$63,201	$75,840	$75,841	$88,480	$88,481	$101,120	$101,121	and over
9	$0	$55,700	$55,701	$69,625	$69,626	$83,550	$83,551	$97,475	$97,476	$111,400	$111,401	and over
10	$0	$60,840	$60,841	$76,050	$76,051	$91,260	$91,261	$106,470	$106,471	$121,680	$121,681	and over
Each Additional $5,140												

MEDICAL/BEHAVIORAL HEALTH	A	B	C	D	E	F
All services per visit	$15	$30	$45	$60	$75	Full Fee
DENTAL	**A**	**B**	**C**	**D**	**E**	**F**
Preventative Services/Emergencies per visit	$15	$30	$45	$60	$75	Full Fee
Expanded Dental Procedures to Include: Sealants, Fillings, Periodontics, Extractions, Endodontics, Crowns, Bridges, Partials, Dentures, Prosthetic Repairs, Space Maintainers, Occlusal Guards and Hard/Soft Tissue Modifications	$15 per visit*	60% Discount^	50% Discount^	30% Discount^	10% Discount^	Full Fee

* If necessary, additional out-of-pocket costs for lab fees will apply.

^ Discount applied to full procedure fee which includes lab fees.

North Country Family Health Center, Inc.
238 Arsenal Street Watertown, NY 13601
phone: 315.782.9450 FAX: 315.782.2643
www.NoCoFamilyHealth.org

Authorization for Release of Health Information

If you are leaving your current primary care provider and choosing to establish care with North Country Family Health Center please complete the next page entitled, “Authorization for Release of Health Information (Including Alcohol/Drug Treatment NEW YORK STATE DEPARTMENT OF HEALTH and Mental Health Information) and Confidential HIV/AIDS related Information”.

Enter your former primary care provider’s name and address on line #5.

Fill in all sections of the form and sign and date the bottom.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. 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. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits 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.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

North Country Family Health Center, Inc.

7. Purpose for Release of Information:

Establishing care with new provider

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.