North Country Family Health Center, Inc.

South Jefferson School District's SBHC Locations
Mannsville Manor Elementary: 315.465.3373
Maynard P. Wilson Elementary: 315.583.5200
Clarke Middle School (Dental Only): 315.779.5611 Watertown City School

Dear Parent/Guardian,

North Country Family Health Center's School-Based Health Program, within the South Jefferson School District, offers medical, dental, and behavioral health services to all students through our School-Based Health Centers (SBHCs). SBHCs bring comprehensive primary care services to the place where students are during the day – school – and address critical health problems as well as urgent concerns that make it difficult for students to learn.

Our SBHCs offer a full range of primary healthcare services to ANY student within the South Jefferson School District. The best part – you do not need to change your primary care provider (medical or dental). Our staff will work in collaboration with any outside provider your student is already seeing. SBHC services include the following:

- Well child and annual physical exams (including sports physicals and working papers)
- Immunizations
- Care for acute illness (such as ear infections and strep throat)
- Care for chronic issues (such as asthma and obesity)
- Behavioral health services (including individual and family counseling)
- Preventative dental care (including cleanings, sealants, and fluoride treatments)

Services provided within the SBHC are provided at no out-of-pocket costs to you – regardless of your child's health insurance coverage. However, if your child requires services we do not provide at our school-based sites – such as outside tests or labs – there may be out of pocket costs. If your child has insurance, we will bill your insurance company for you. If your child does not have insurance, we can assist you with obtaining insurance coverage. We do NOT turn any student away!

Our Program is voluntary – however, we encourage you to enroll as a backup plan in case your child falls ill while at school as well as to take advantage of our school-based services as they are convenient for both you and your child. North Country Family Health Center has over 30 years of experience providing school-based services to students. We know firsthand that healthy students learn better. We encourage you to enroll your child so we can focus on their health so they can focus on learning.

Please complete the attached enrollment packet to enroll your child in school-based services. If you would like more information or have questions, contact me directly at hlupia@nocofamilyhealth.org or 315-782-9450 x8086. For dental-specific questions please contact Nicole Quintin, Dental Services Director, at 315-782-9450 ext. 8094 or nquintin@nocofamilyhealth.org.

Sincerely,

Heather Lupia, MS, Healthcare Administration
Primary Care Services Director

Use our QR code to learn more about our SBHC Program

School-Based Health Center Transportation Plan for South Jefferson Central School District

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

NCFHC will provide transportation for Clarke students to attend medical, dental, and behavioral health 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. **The Transportation Consent, Waiver, and Release must be signed on the attached School-Based Health Center Enrollment Form for NCFHC to provide transportation services to your enrolled student.**

When a Clarke student must travel to an appointment at the Wilson or Mannsville Elementary SBHC, the NCFHC staff member 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. Once at the Mannsville or Wilson SBHC, the NCFHC staff will walk students into the SBHC for their appointment. Once back at Clarke, the NCFHC staff will walk students back to the Attendance Office. The student will then sign back in and return to class.

N★Co Family Health

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

Today's Date:

School-Based Health Center (SBHC)
2024-2025 Enrollment Form

What Services Do You Want to Enroll Your Student In (Check All That Apply):			☐ Medical ☐ Dental ☐ Behavioral Health Services at Our School-Based Site
My Student Information:			
Last Name:	First Name:		Full Middle Name:
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Street Address:	
Student's School:	Grade:		Teacher/Homeroom:
Biological Mother's First Name and Maiden Name:			BOCES Student ☐ Yes ☐ No If Yes, ☐ AM BOCES ☐ PM BOCES
Student's Primary Care Doctor's Name:			☐ My Student Doesn't Have a Regular Doctor
Student's Primary Dentist Name:			☐ My Student Doesn't Have a Regular Dentist
Preferred Pharmacy Name:			Address:

Parent/Guardian # 1 Information:	**Parent/Guardian # 2 Information:**
Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Step-Parent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other (Please Define):	Relationship to Student: ☐ Father ☐ Mother ☐ Step-Parent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other (Please Define):
Mailing Address (If Different than Student):	Mailing Address (If Different than Student):
Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No	Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No

Who Does My Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Step-Parent ☐ Other:

Who Will Make Healthcare Decisions for My Student: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Step Parent ☐ Other:

Do We Have Permission to Call the Student's Emergency Contact You Provided to the School: ☐ Yes ☐ No

North Country Family Health Center, as a Federally Qualified Health Center, MUST Ask You to Complete the Following Questions (PLEASE FILL OUT ALL SECTIONS BELOW RESPONDING FOR YOUR STUDENT):

Household Size & Income (Enter Child's Family Information):
Number of People in the Household: _____ Income $_____ ☐ Week ☐ Month ☐ Year

What Gender Does Your Student Identify as:
☐ Male ☐ Female ☐ Transgender Male: Female to Male ☐ Transgender Female: Male to Female
☐Gender Non-Conforming (Neither Exclusively Male nor Female)
☐ Additional Gender Category /Other (Please Specify): _____ ☐ Choose Not to Disclose

Student Sexual Preference/What Does Your Student Think of Themselves as:
☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not to Disclose

Student's Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐Choose Not to Disclose

Student's Ethnicity: ☐None ☐Hispanic or Latino/Spanish ☐Latin American/Latin ☐Puerto Rican ☐South American ☐Spaniard

Student Name: _____ Date of Birth: _____

Student's Race: ☐White ☐Black or African American ☐ Asian ☐American Indian or Alaskan Native ☐Native Hawaiian/Pacific Islander	
Student's Primary Language: ☐English ☐Spanish ☐Other (Please Specify):	
Primary Medical Insurance	**Dental Insurance**
☐ My Student ***Has*** Medical Insurance ☐ My Student ***Does Not*** Have *Medical* Insurance Please 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.	☐ My Student ***Has*** *Dental* Insurance ☐ My Student ***Does Not*** Have *Dental* Insurance Please 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 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 (Name of Insurance):	☐ I have additional ***Dental*** Insurance (Name of Insurance):
Required Medical History:	
Has Your Student Been Diagnosed With 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:	
Date of Your Student's Last Physical Exam: Provider Name:	
Would You Like Your Student Next Physical Exam Completed at the School-Based Health Center? ☐ No ☐ Yes	
Has Your Student Had Any Surgeries? ☐ No ☐ Yes (Please List):	
Has Your Student Been Hospitalized? ☐ No ☐ Yes (Please List):	
Has Your Student Been Referred to a Healthcare Specialist? ☐ No ☐ Yes (Name & Phone # of Specialist):	
Does Your Student Take Daily Medications: ☐ No ☐ Yes (Please List):	
Does Your Student Have Any Allergies: ☐ No ☐ Yes (Please List):	
Does Anyone in the Home Smoke or Vape? ☐ No ☐ Yes	
Do You Have a Family History for Any of the Following Conditions? (Mother, Father, Siblings, and/or Grandparents) ☐Stroke ☐Cancer ☐Obesity ☐Diabetes ☐Epilepsy ☐TB ☐Asthma ☐Sickle Cell Trait ☐Thyroid ☐ Mental Health	

Student Name: _____ Date of Birth: _____

If Yes, Please Explain:

Cardiac Screening Questions:

Have You Ever Been Told by a Healthcare Provider Your Child Has a Heart or Blood Pressure Problem?
☐ No ☐ Yes If Yes, Please Explain:

Since Your Child's Last Physical Exam Has Your Child Complained of: ☐Light Headedness ☐Dizziness ☐Excessive Fatigue ☐Shortness of Breath ☐Passed Out After Exercise If Yes, Please Explain:

Is There a Family History of Sudden or Unexpected Death in a Person Less than 50 years old (Mother, Father, Siblings, and/or Grandparents)? ☐ No ☐ Yes

Is There a Family History of: ☐Cardiomyopathy ☐ Marfan Syndrome ☐ Arrhythmia ☐Brugada Syndrome ☐ Long or Short QT Interval ☐Heart Attack at Age 50 or Younger ☐Any Other Heart Issue
If Yes, Please Explain:

Dental Services Screening Questions: Please Complete for Your Student if Requesting Dental Services:
☐Not Requesting Services

Does the Student Have Any Current Dental Problems? ☐ No ☐ Yes (Please Explain):

Has the Student Had Problems with Dental Treatment? ☐ No ☐ Yes (Please Explain):

Has the Student Had Any Injury to the Mouth or Teeth? ☐ No ☐ Yes (Please Explain):

Behavioral Health Services Screening Questions: Please Complete for Your Student if Requesting Behavioral Health Services ☐ Not Requesting Services

Does Your Student Currently See a Behavioral Health Therapist Outside of School? ☐ No ☐ Yes (Please Explain):

Does Your Student Currently Work with a School Counselor? ☐ No ☐ Yes (Please Explain):

Does Your Student Receive IEP Counseling Provided by the School? ☐ No ☐ Yes (Please Explain):

Are You Concerned About Your Student's Attitude or Behaviors? ☐ No ☐ Yes (Please Explain):

Do You Have Any Concerns with Your Child at School: ☐Poor Academics ☐Suspensions or Detentions ☐Attention Concerns
If Yes, Please Explain:

North Country Family Health Center Policies and Consents

Consent for School-Based Health Services: I authorize my student to receive services provided by the staff of North Country Family Health Center's (NCFHC) School-Based Health Program. Services may include, but are not limited to, comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and behavioral health 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 including the NYS Health Examination Form and Interval Health History for Athletics Form 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 believe 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

Student Name: _____ **Date of Birth:** _____

School-Based Health Center at any time. If I have questions about enrolling my student and/or the SBHC Program, I will contact Heather Lupia, Primary Care Services Director at (315) 782-9450 x 8086 or Nicole Quintin, Dental Program Director, at 315-782-9450 x8094.

Permission to Disclose to Family or Other Individuals (Non-Parents/Guardians): For patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions. 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). Parents do not need to be included here.

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

☐ **Yes**, I give consent for the following adult(s) to attend, give consent for services, and/or make treatment decisions for my child in my absence. This consent is valid for one year from the date of signature unless revoked in writing prior to expiration. I understand that I may revoke my consent at any time.

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 within the School-Based Health Program such as 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, please call our Certified Application Counselor at 315-782-9450 x 8038. 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 North Country Family Health Center, Inc. for services rendered.

Notice of Privacy Practices: 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 is posted in the SBHC. You may also visit www.nocofamilyhealth.org for a copy.

- 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/dental/behavioral health 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, Parkview Pharmacy, and call reminder service including text messages.
- I understand NCFHC may use letters, reminder calls, text messages, or secure email correspondences to communicate with me regarding my student's care. I authorize NCFHC to communicate with me via these methods and understand this correspondence may contain PHI.
- I understand NCFHC may use computer assisted technologies guided by our internal policy & procedures to enhance my care, with all data processed securely and all clinical decisions made by a qualified healthcare provider.

Telehealth: North Country Family Health Center's (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 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 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.

Student Name: _____ Date of Birth: _____

- 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.
- I understand my student has the right to have appropriately trained staff immediately available 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.

Transportation Consent, Waiver, & Release: I give consent for my student to be transported by NCFHC staff for the 2024-2025 school year in connection with non-emergency healthcare services and will assume all liability for my student's participation in these transportation services. I understand transportation is by appointment only. I have read, acknowledge, consent and agree to the following transportation waiver/release on behalf of my student:

- I recognize and acknowledge NCFHC is neither a common carrier, nor in the business of providing transportation services to the public, and there are certain inherent risks of physical injury to vehicle passengers in the course of transportation. I knowingly, willingly, and voluntarily agree to assume any and all risk associated with my student receiving transportation services offered by 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.
- I will not hold NCFHC, its officers, agents, employees, assigns, or anyone acting on its behalf, responsible or liable for injury occurring to my student in the course of such transportation services.
- I agree to waive and release all claims I may have, or which may accrue against NCFHC, including its respected officers, agents, employees, assigns, or anyone acting on its behalf. I do hereby fully release and forever discharge NCFHC from any and all claims for injuries, damages, or loss that my student may have or which may accrue to me or my student and arising out of, connected with, or in any way associated with said transportation services.
- My student will agree to refrain from eating, drinking, and smoking in the course of transportation services offered by NCFHC.
- I understand this agreement shall be governed by the laws of the State of New York.
- I understand this Consent, Waiver, and Release for transportation is valid unless revoked in writing prior to expiration.

Consent to Release Educational Information: The information contained in your student's education records is protected by a Federal privacy law known as the Family Educational Rights and Privacy Act (FERPA). Except under limited exceptions specified in FERPA, school officials can **only** share your student's education records or discuss information from your student's records with third parties if you provide "prior written consent" that is, your explicit permission in writing.

- To provide comprehensive care to your child, North Country Family Health Center is requesting education information on your student. This may include, but is not limited to, academic performance, school health information, IEP reports, teacher reports, ADHD teacher rating scales, and/or report forms.
- I understand this consent will authorize the release of my student's education records to North Country Family Health Center for continuity of care.
- I understand this release gives your student's school district staff the authorization to speak to North Country Family Health Center staff about their academic performance.

My Signature Below Means:

Printed Name of Legally Authorized Representative:	Relationship to Student:
Signature of Legally Authorized Representative:	Date:

North Country Family Health Center, Inc.

CONSENT FOR RELEASE OF MEDICAL AND DENTAL INFORMATION

Complete this Form if Your Student is **NOT** a Current Medical or Dental Patient of North Country Family Health Center

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 behavioral 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 my 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.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Complete This Section if Your 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

My 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 my student's primary care provider and my 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

- ☒ All immunizations
- ☒ Past two years of lab tests, imaging, and procedures
- ☒ Past year of behavioral health treatment

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

CONSENT FOR RELEASE OF DENTAL INFORMATION

Complete This Section if Your Student is NOT a Current Dental Patient of North Country Family Health Center to Ensure Coordination of Care with Your Child's Dentist

My 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 your student's Dentist and your 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:**

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 on this form will NOT affect my ability to get medical care. The choice I make on 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**.**