Partners in Care: Patients and Health Care Teams working together on your health care and ongoing wellness. Together we can make your medical appointment work for you!

Your Enrollment Packet includes the following forms to be completed and additional information:

- Patient Registration Form
- Health History Form & Dental History Form (also complete if requesting Dental Services)
- Consent for Treatment Form
- Obtain PHI (Medical Records) Information Form
- HIXNY Consent Form (ONLY for Primary Care, Behavioral Health & Neurology services)
- Center Health Care Services
- Directions to Center Health Care

Before your appointment:

- Read all information in your Enrollment packet, complete necessary forms and return in self addressed envelope.
- When calling for an appointment at (518) 437-5900, please allow 2 weeks for Center Health Care to receive and process your paperwork.
- Make a list of your questions and concerns.
- If you have seen a specialist, ask them to send your reports to our Medical Records Department.
- Check with your insurance company regarding co-pays, deductibles and co-insurance fees.
- If you will be a patient of our Primary Care practice, call your insurance company to choose a Center Primary Care Provider.
- You will receive a confirmation call 2 days prior to your appointment.
- Call our office at (518) 437-5900, well in advance, if you need to reschedule your appointment.

On the day of your appointment:

- Keep your scheduled appointment.
- Arrive 15 minutes before your scheduled appointment time to allow time for parking, check-in and additional paperwork, if necessary.
- Bring the following information to your appointment:
  - Photo ID
  - All your Medicaid, Medicare and/or Insurance Cards
  - All completed forms included in the Enrollment Packet, if not returned by mail.
- Bring payment or co-pay for your appointment. We accept cash, checks, MasterCard & Visa credit cards and flex spending accounts.

During your appointment:

- Your commitment:
  - Ask your medical provider questions about your health concerns, treatment plans, wellness recommendations and disease prevention, and lifestyle changes.
- Our Health Team’s commitment:
  - Make you feel comfortable and welcome
  - Provide best treatment and advice based on current medical evidence
  - Manage acute illness and chronic conditions
  - Support you in your health care goals
  - Answer your questions
  - Respect your privacy
## PATIENT INFORMATION

### What service(s) are you requesting:
- [ ] Primary Care
- [ ] Dental
- [ ] Behavioral Health
- [ ] Specialty Medical
- [ ] OT / PT

### Indicate your main medical concern


### Preferred Name


### Primary Address

City: ____________________________  State: ___________  Zip: ___________

### Home Phone

( ____________________________ )

- Can we call?  [ ] Yes  [ ] No
- Leave Voicemail?  [ ] Yes  [ ] No

### Work Phone

( ____________________________ )

- Can we call?  [ ] Yes  [ ] No
- Leave Voicemail?  [ ] Yes  [ ] No

### Cell Phone

( ____________________________ )

- Can we call?  [ ] Yes  [ ] No
- Leave Voicemail?  [ ] Yes  [ ] No
- Text?  [ ] Yes  [ ] No

### Primary Care Physician Name

( ____________________________ )

### Office Phone

( ____________________________ )

### Office Fax #

( ____________________________ )

### PERSON RESPONSIBLE FOR CO-PAY & CO-INSURANCE

- [ ] Same as Patient  [ ] If NOT same as Patient, please complete.

### Name (First, Last)

( ____________________________ )

### Address

City: ____________________________  State: ___________  Zip: ___________

### Home Phone

( ____________________________ )

### Work Phone

( ____________________________ )

### Cell Phone

( ____________________________ )

### Date of Birth

( ____________________________ )

## CENTER HEALTH CARE

### Patient Registration

- [ ] PC
- [ ] DEN
- [ ] BH
- [ ] SPMED
- [ ] OT / PT

### Marital Status

- [ ] Widowed
- [ ] Single
- [ ] Divorced
- [ ] Married
- [ ] Separated

### E-Mail

( ____________________________ )

- Patient Portal Access Authorization  [ ]

### Race (can select up to 2 options)

- [ ] White
- [ ] African American
- [ ] Chinese
- [ ] Japanese
- [ ] Asian
- [ ] Filipino
- [ ] American Indian or Alaska Native
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] Something else, please specify:
  - Patient Declined  [ ]

### Ethnicity (can select up to 2 options)

- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino
- [ ] Patient Declined  [ ]

### Primary Language

- [ ] English
- [ ] Something else, please specify:

### Gender Identity

- [ ] Identifies as Male
- [ ] Identifies as Female
- [ ] Female to Male
- [ ] Male to Female
- [ ] Gender Queer (neither male/female)
- [ ] Other Gender, please specify:
- [ ] Choose not to disclose

### Sex

- [ ] Male
- [ ] Female
- [ ] Undefined

### Sexual Orientation

- [ ] Straight/Heterosexual
- [ ] Lesbian, Gay or Homosexual
- [ ] Bisexual
- [ ] Something else, please specify:
- [ ] Don’t know
- [ ] Choose not to disclose

### Employer Name

( ____________________________ )

### Employer Address

( ____________________________ )

### Relationship to Patient

- [ ] Self
- [ ] Child
- [ ] Spouse
- [ ] Partner
## INSURANCE INFORMATION

- **MEDICARE**  Medicare #
- **MEDICAID**  Medicaid #
- **If Uninsured – Sliding Scale Requested**

## OTHER INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Group #</th>
<th>ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subscriber's Name (First, Last)</th>
<th>Relationship to Patient</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Child</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partner</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber's Date of Birth</th>
</tr>
</thead>
</table>

## DENTAL INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Dental Insurance Carrier</th>
<th>Dental Insurance Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Insurance Phone</th>
<th>Dental Group #</th>
<th>Dental ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>(</td>
<td></td>
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<table>
<thead>
<tr>
<th>Subscriber's Name (First, Last)</th>
<th>Relationship to Subscriber</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
</tr>
<tr>
<td></td>
<td>Child</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td></td>
<td>Partner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscriber's Date of Birth</th>
</tr>
</thead>
</table>

## EMERGENCY / CAREGIVER CONTACT

<table>
<thead>
<tr>
<th>Name (First, Last)</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>(</td>
<td>(         )</td>
<td>(         )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Other Information or Contact</th>
<th>Primary Spoken Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner/Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## SERVICE COORDINATOR

<table>
<thead>
<tr>
<th>Name of Service Coordinator (First, Last)</th>
<th>Work Phone</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(         )</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Agency Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Zip</td>
</tr>
</tbody>
</table>

## PHARMACY INFORMATION

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Pharmacy Phone</th>
<th>Pharmacy Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(             )</td>
<td>(             )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

## ADDITIONAL INFORMATION REQUESTED (Required Per Federal Guidelines)

<table>
<thead>
<tr>
<th>Veteran Status</th>
<th>Educational Level</th>
<th>Agriculture Work Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>High School</td>
<td>Non Agricultural</td>
</tr>
<tr>
<td>Non-Veteran</td>
<td>AS College</td>
<td>Seasonal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Citizenship</th>
<th>Income Status</th>
<th>Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Citizen by Birth</td>
<td>Unknown/Refused to Provide</td>
<td>What is your family size?</td>
</tr>
<tr>
<td>US Citizen First Generation</td>
<td>Patient has income</td>
<td></td>
</tr>
<tr>
<td>Immigrant</td>
<td>Masters Degree</td>
<td>Employee Year - Round</td>
</tr>
<tr>
<td>Naturalized</td>
<td>BS College</td>
<td>Migrant</td>
</tr>
<tr>
<td>Permanent Resident or Alien</td>
<td>Doctorate Degree</td>
<td>Retired Farm Worker</td>
</tr>
<tr>
<td>Other</td>
<td>None</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Status</th>
<th>Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown/Refused to Provide</td>
<td>What is your family size?</td>
</tr>
<tr>
<td>Patient has income</td>
<td></td>
</tr>
</tbody>
</table>
### INCOME INFORMATION

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Source of Income (if more than 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Child Support</td>
<td>☐ Child Support</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Other</td>
</tr>
<tr>
<td>☐ Salary</td>
<td>☐ Salary</td>
</tr>
<tr>
<td>☐ Salary 2</td>
<td>☐ Salary 2</td>
</tr>
<tr>
<td>☐ Social Security</td>
<td>☐ Social Security</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Type of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ W-2</td>
<td>☐ W-2</td>
</tr>
<tr>
<td>☐ 1099</td>
<td>☐ 1099</td>
</tr>
<tr>
<td>☐ Form 1040</td>
<td>☐ Form 1040</td>
</tr>
<tr>
<td>☐ Paystub</td>
<td>☐ Paystub</td>
</tr>
<tr>
<td>☐ Employer Letter</td>
<td>☐ Employer Letter</td>
</tr>
<tr>
<td>☐ Other</td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

**Amount of Income** $________________

**Frequency of Income**
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Bi-Monthly
- ☐ Monthly
- ☐ Annually

**Amount of Income** $________________

**Frequency of Income**
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Bi-Monthly
- ☐ Monthly
- ☐ Annually

### HOUSING / LIVING ARRANGEMENT

**What is your current housing status/living arrangement?**
- ☐ Private Home
- ☐ Residence
- ☐ Supportive Living
- ☐ Public Housing
- ☐ Homeless

If Residence/Supportive Living, please specify which **Agency:**
________________________________________________________________

If homeless, please specify what your current situation is.
- ☐ Shelter
- ☐ Transitional
- ☐ Doubling Up
- ☐ Street
- ☐ Other
- ☐ Unknown

### REFERRAL INFORMATION

Who referred you to Center Health Care?
________________________________________________________________

If a Physician’s Office, please give Name and Address
________________________________________________________________

The reason you are being referred:
________________________________________________________________

### FORM COMPLETED INFORMATION

Who completed the above information?
- ☐ Patient named on top of form
- ☐ Caregiver

Print Name________________________________________ Date ____________
**Personal Information**  (Please print)

**Date** ____ / ____ / _____

**Indicate your main medical concern** __________________________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Date of Birth</th>
<th>Occupation</th>
<th>Religion</th>
<th>How far did you go in school?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Marital status:**
  - Single ☐
  - Married ☐
  - Separated ☐
  - Divorce ☐
  - Widow ☐
  - Birthplace: __________________________

**Medical History**

**Diagnosis**
- Developmental Disability ☐
- Traumatic Brain Injury ☐
- Autism ☐
- Other: __________________________________________________

**List allergies to medicines** __________________________________________

**Do you smoke?**
- YES ☐
- NO ☐
- How much? ________________
- For how many years? _______

**Do you want to stop smoking?**
- YES ☐
- NO ☐

**Do you drink alcohol?**
- Never ☐
- Rarely ☐
- Daily ☐
- Socially ☐
- Do you have a drinking problem?  YES ☐
- NO ☐

**Are you on a special diet?**
- YES ☐
- NO ☐

**List all Medications you use** (including those not needing a prescription)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Previous Hospitalizations** (not including normal pregnancies)

<table>
<thead>
<tr>
<th>Operation or Illness</th>
<th>Hospital / Doctor</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Check ✓ if you have ever had:**

<table>
<thead>
<tr>
<th>EARS</th>
<th>Low Blood Pressure</th>
<th>Dementia</th>
<th>Alzheimers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Impairment</td>
<td>GI</td>
<td>Headaches</td>
<td>Bladder Disorder</td>
</tr>
<tr>
<td>ENT</td>
<td>Diverticulitis</td>
<td>Multiple Sclerosis</td>
<td>Blood Transfusion</td>
</tr>
<tr>
<td>Dry Mouth</td>
<td>Gall Bladder Disease</td>
<td>Neuropathy</td>
<td>Breast Lump</td>
</tr>
<tr>
<td>Gag Reflex Concerns</td>
<td>Jaundice</td>
<td>Parkinsons</td>
<td>Cervical Disorder</td>
</tr>
<tr>
<td>Swallowing Disorder</td>
<td>Ulcer</td>
<td>Seizure/Epilepsy</td>
<td>Developmental Disability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shunt (Cerebral)</td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td>GU</td>
<td>Strokes</td>
<td>Exposure to TB</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Kidney Disease</td>
<td>Traumatic Brain Injury</td>
<td>German Measles (Rubella)</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Urinary Infections</td>
<td>Tremors</td>
<td>History of Cancer</td>
</tr>
<tr>
<td>Vision Impairment</td>
<td></td>
<td>Unconsciousness</td>
<td>Joint Replacement:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Specify)</td>
</tr>
<tr>
<td>CARDIOVASCULAR</td>
<td>Arthritis/Lupus</td>
<td>RESPIRATORY</td>
<td>Measles</td>
</tr>
<tr>
<td>Central Valve Disorder</td>
<td>Fractures</td>
<td>Asthma</td>
<td>Mumps</td>
</tr>
<tr>
<td>Circulatory Problems</td>
<td>Gout</td>
<td>Emphysema/COPD</td>
<td>Organ Transplant:</td>
</tr>
<tr>
<td>Elevated Cholesterol</td>
<td>Joint Replacement</td>
<td>Hay Fever</td>
<td>(Specify)</td>
</tr>
<tr>
<td>Enlarged Heart</td>
<td>Osteoporosis</td>
<td>Pneumonia</td>
<td>Radiation/Chemotherapy</td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>NEUROLOGICAL</td>
<td>OTHER</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Cerebral Palsy</td>
<td>ADHD</td>
<td>Thyroid Disease</td>
</tr>
</tbody>
</table>
List the year you last had: (write NONE if never had)

- Chest X-ray _______
- Electrocardiogram _______
- TB Test (Skin) _______
- Tetanus Shot _______
- Diphtheria Shot _______
- Polio Vaccine _______
- Flu Vaccine _______
- Measles Shot _______
- Rubella Shot _______
- Mumps Shot _______
- Pap Smear Test _______
- Vision Test _______
- Breathing Test _______
- Hearing Test _______

**Family History**

For your family members below, follow the line across the page and mark an X in those boxes which indicate any illness they have ever had.

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>Diabetes</th>
<th>Cancer</th>
<th>Heart</th>
<th>High Blood</th>
<th>Stroke</th>
<th>Mental</th>
<th>Bleeding</th>
<th>Kidney</th>
<th>Age of Death</th>
<th>If Deceased, Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Brothers</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Spouse</td>
<td></td>
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<tr>
<td>Children</td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Dental History**

- Date of last dental visit ______________ Name of Dental Office ______________________________________________
- Date of most recent dental x-ray? __________ Location ____________________________________________________________

Has the patient taken any of the following to assist with dental treatment:
- ☐ Nitrous Oxide  ☐ General Anesthesia  ☐ Anti-anxiety Medication (Name & Dose) ________________________________

Has the patient ever required medical immobilization/protective stabilization support to facilitate dental treatment?
- YES ☐ NO ☐ Please check: ☐ Papoose Board  ☐ Head Stabilization  ☐ Hands Held  ☐ Arm restraints

If the patient utilizes a wheelchair, can they transfer to a dental chair?  YES ☐ NO ☐

Are there any current dental concerns?  YES ☐ NO ☐

Please explain_________________________________________________________________________________________
Dental Information (Please print) Date ___ / ___ / ______

Name_________________________________________________________________________ Age ______ Date of Birth ____ / ____ / ______

Date of last dental visit ______________________

Name of Dental Office ___________________________________________________________________________

Address of Dental Office_______________________________________________________________________________________

Treatment Completed (please check):

☐ Exam by Dentist
☐ Cleaning
☐ Full Services X-rays
☐ Bitewing X-rays
☐ Filling
☐ Extraction

Is the patient comfortable receiving dental treatment?  YES ☐  NO ☐

Has the patient taken any of the following to assist with dental treatment?

☐ Nitrous Oxide  ☐ General Anesthesia
☐ Oral Anti-anxiety Medication (Name & Dose) __________________________________________

Has the patient ever required medical immobilization / protective stabilization support to facilitate dental treatment?  YES ☐  NO ☐  Please check below:

☐ Papoose Board  ☐ Head Stabilization  ☐ Hands Held  ☐ Arm restraints

If the patient utilizes a wheelchair, can they transfer to a dental chair?  YES ☐  NO ☐

Are there any current dental concerns?  YES ☐  NO ☐

Please explain__________________________________________________________

If the patient has been referred by a dental professional, please state the reason:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Additional Information Requested (Required Per Federal Guidelines)

Race of Patient:  ☐ Caucasian  ☐ African American  ☐ Asian
☐ Native American/Alaska Native  ☐ Native Hawaiian

Ethnicity of Patient:  ☐ Non-Hispanic  ☐ Hispanic/Latino  ☐ Decline

Language of Patient:  ☐ English  ☐ Spanish  ☐ Other
CENTER HEALTH CARE

Consent to Treat

Patient Name (please print) ____________________________________ Patient ID # _______________

Patient Date of Birth ______________________________

AUTHORIZATION FOR MEDICAL TREATMENT
I hereby give consent to Center Health Care staff physicians, nurse practitioners, physician assistants, nurses, dentist providers, and therapists involved in the care of (patient’s name):

_____________________________________________________. To provide medical or dental services, and perform such treatment, operations, or procedures that are necessary in the normal course of providing these services. Certain procedures may require additional informed consent to be signed.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of Center Health Care (HIPAA) Notice of Privacy Practices. This notice describes how CHC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and privacy rights I have regarding my protected health information. In accordance with this policy CHC, its provider(s) and staff, may leave me a detailed phone message related to my care or send me appointment reminder cards.

RELEASE OF MEDICAL INFORMATION
I hereby authorize and direct Center Health Care to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS
I authorize payment of insurance and/or Medicare benefits directly to Center Health Care for the services of its providers and staff in rendering my care. In addition, I authorize the release of any medical information to allow the insurance company and/or Medicare to process any claim(s) filed.

______________________________________ ________  _________________
Signature of Patient / Responsible Party    Date

Updated: 10/5/17
CENTER HEALTH CARE
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

This authorization is written permission for an outside agency to disclose Protected Health Information (PHI) as directed.

Patient Name:_______________________________________ Phone: (      )_________________________

Former/Maiden Name:________________________________ DOB:______/______/_______

Address:_________________________________________________________________________________

Street      City   State         Zip

I,_____________________________________________  hereby authorize _____________________________

Address:_________________________________________________________________________________

Street      City   State         Zip
to disclose Protected Health Information (PHI) to:

**Center Health Care**
**Attn:**  Medical Records Department/
_______________________________ (Provider’s Name)
314 So. Manning Blvd.
Albany, NY  12208
Phone: (518) 437-5710  Fax: (518) 437-5711

The specific information to be disclosed, includes: (describe the information, including but not limited to, descriptors such as date of services, type of service, level of detail to be released, etc.)

- Entire Medical Record
- Copies of progress notes from ________________________________ (Provider/Specialty) for the following dates: ________________________________
- Immunizations
- Dental X-rays
- Dental Treatment Records
- Tests/Evals : ________________________________ : ____/____/_____  ____/____/_____  
  Type of Test/Eval Date Date
- Verbal exchange between: ________________________________ / ________________________________ and
  Name of Individual  Agency
  ________________________________ at Center Health Care
- Other (please be specific): ________________________________

The PHI is being disclosed for the following purposes:

- Change of provider
- Verbal Exchange
- At my request
- Other: ________________________________

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure (with the exception of HIV information) and may no longer be protected by state or federal law. I understand that this authorization will expire one (1) year from the date of signature unless a shorter period is noted here. ( _____/_____/_____ - expiration date)

____________________________________    _______________________________    _____/_____/_____
Signature of Patient or Legal Representative              Relationship to patient/representative's authority           Date

Update: June 2018
In this Consent Form, you can choose whether to allow Center Health Care to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as Hixny, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Center Health Care to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.

If you check the “I GIVE CONSENT” box below, you are saying “Yes, Center Health Care’s staff involved in my care may see and get access to all of my medical records through Hixny.”

If you check the “I DENY CONSENT” box below, you are saying “No, Center Health Care may not be given access to my medical records through Hixny for any purpose.”

Hixny is a not-for-profit organization. It shares information about people’s health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future.

You have two choices.

☐ I GIVE CONSENT for the specified service(s) in Center Health Care to access ALL of my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

I AM ENROLLING IN THE FOLLOWING SERVICE(S):

☐ Primary Care ☐ Behavioral Health ☐ Neurology

☐ I DENY CONSENT for Center Health Care to access my electronic health information through Hixny for any purpose, even in a medical emergency.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.
Details about patient information in Hixny and the consent process:

How Your Information will be Used
Your electronic health information will be used by Center Health Care only to:
•Provide you with medical treatment and related services
•Check whether you have health insurance and what it covers
•Evaluate and improve the quality of medical care provided to all patients

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information about You Are Included
If you give consent, Center Health Care may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. 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 relate to 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, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.

Where Health Information about You Comes From
Information about you comes from places that have provided you with medical care or health insurance (“Information Sources”). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information about You, If You Give Consent
Only these people may access information about you: doctors and other health care providers who serve on Center Health Care’s medical staff who are involved in your medical care; health care providers who are covering or on call for Center Health Care’s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 at (518) 437-5710; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (518) 474-4987.

Re-disclosure of Information
Any electronic health information about you may be re-disclosed by Center Health Care to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period
This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent
You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Center Health Care. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021. NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form You are entitled to get a copy of this Consent Form after you sign it.