Center for Disability Services
Where people get better at life

CENTER HEALTH CARE

314 S. Manning Blvd., Albany, NY 12208
8:00 am – 5:00 pm (Monday - Friday)

Main Phone # (518) 437-5900   Fax # (518) 437-5554

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/signed and additional information:

- **Patient Registration Form**
- **Health History Form & Dental History Form** *(complete if requesting Dental Services)*
- **Behavioral Health Background Questionnaire** *(complete if requesting Behavioral Health Services)*
- **Consent for Treatment Form**
- **Patient's Bill of Rights Form**
- **Obtain PHI (Medical Records) Information Form**
- **HIXNY Consent Form** *(ONLY required for Primary Care, Behavioral Health & Neurology services)*
- **Health Care Proxy Form**
- Center Health Care Services & Directions to Center Health Care

Before your appointment:

- **Read all information in your Enrollment packet, complete and sign the necessary forms and return in the enclosed 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

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PRIMARY CARE

- Primary Care (Pediatric and Adult) – Ages 5 and up
- Preventive Women's Health

BEHAVIORAL HEALTH

- Psychiatry (Pediatric and Adult) – Ages 5 and up
  *Services available only to individuals with Developmental Disabilities/Intellectual Disabilities
- Counseling (Individual and Group) – Ages 5 and up

DENTAL

- Comprehensive exams
- X-rays
- Cleanings
- Restorations
- Sealants
- Fluoride treatments
- Prosthetics (dentures, partials)
- Preventive education

SPECIALTY MEDICAL

- Physiatry (Spasticity Management and Botox)
- Audiology
- Podiatry
- Neurology

OUTPATIENT THERAPY

Available to OPWDD recipients only. Ages 5 and up.

- Physical Therapy (including Pool Therapy)
- Occupational Therapy

WELLNESS/AQUATICS – CALL (518) 437-5714

- Heated Therapeutic Pool
- Swim Lessons and Birthday Parties
- Senior Wellness Swim Program

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CENTER HEALTH CARE

Directions

314 South Manning Boulevard
Albany, New York 12208
Main Phone # (518) 437-5900

TRAVELING FROM SOUTH AND WEST

- Take the **THRUWAY TO EXIT 24**
- Take **I-90 EAST TO EXIT 4** (*Slingerlands*)
- Take **KRUMKILL ROAD** Exit*
    - At the end of the exit ramp, take a left over the bridge
    - Turn right at the traffic light and follow this road to the next traffic light
    - At light, take a left onto **New Scotland Avenue**
    - At the 2nd traffic light, turn right onto **SOUTH MANNING BOULEVARD**
    - The Center for Disability Services will be on your right after the first traffic light.

TRAVELING FROM THE NORTH

- Take the **NORTHWAY (I-87)** Southbound
- Take **I-90 EAST TO EXIT 4** (*Slingerlands*)
- Take **KRUMKILL ROAD** Exit*
    - Follow directions above*

TRAVELING FROM THE EAST/VERMONT/TROY AREA VIA 787

- Take **787 SOUTH** towards Albany
- Take **I-90 WEST TO EXIT 4** (*Slingerlands*)
- Take **KRUMKILL ROAD** Exit
    - Follow directions above*

TRAVELING FROM NEW ENGLAND AND BERKSHIRE SPUR OF NEW YORK THRUWAY (VIA I-90)

- Take **EXIT B-1 NEW YORK THRUWAY/BERKSHIRE SPUR**
- This will take you directly to **I-90 WESTBOUND** (*towards Albany*)
- Take **EXIT 4** (*Slingerlands*)
- Take **KRUMKILL ROAD** Exit*
    - Follow directions above*

CENTER HEALTH CARE ENTRANCE

Enter **DOOR # 8** – Main Entrance to all clinics and central Patient Registration

PARKING

Convenient and accessible parking is available in the front of the building.

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CENTER HEALTH CARE

Patient Registration

Today's Date______________ **Patient #**______________

What service are you requesting ☑:

☐ Primary Care *(ages 5 up)* ☐ Dental ☐ Psychiatry: for Developmental Disabilities/Intellectual Disabilities **only** *(ages 5 up)*
☐ Preventive Women's Health ☐ Physiatry ☐ Neurology *(ages 12 up)* ☐ Social Work/Counseling *(ages 5 up)*
☐ Audiology ☐ Podiatry ☐ OT / PT (OPWDD recipients **only**) *(ages 5 up)*

Indicate your main medical concern: ______________________________

Name (First, Middle, Last)

Preferred Name

Date of Birth / /

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Primary Address

City **State** **Zip**

E-Mail

☐ YES - Patient Portal Access Authorization

Home Phone (   )
Can we call? ☐ Yes ☐ No
Leave Voicemail? ☐ Yes ☐ No

Work Phone (   )
Can we call? ☐ Yes ☐ No

Cell Phone (   )
Can we call? ☐ Yes ☐ No
Leave Voicemail? ☐ Yes ☐ No
Text? ☐ Yes ☐ No

Primary Care Physician Name

Office Phone (   )

Office Fax # (   )

Address **City** **State** **Zip**

Primary Language
☐ English
☐ Something else, please specify:

Ethnicity
(can select up to 2 options)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient Declined

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

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

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	E-Mail	Primary Spoken Language
Employer Name ______ Employer Address		Relationship to Patient ☐ Self ☐ Child ☐ Spouse ☐ Partner

INSURANCE INFORMATION - PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

☐ **MEDICARE** Medicare #______

☐ **MEDICAID** Medicaid #______

☐ **If Uninsured – Sliding Scale Requested**

OTHER INSURANCE INFORMATION

Insurance Carrier	Group #	ID #
Subscriber's Name (First, Last) Subscriber's Date of Birth	Relationship to Patient ☐ Self ☐ Child ☐ Spouse ☐ Partner	Gender ☐ Male ☐ Female

DENTAL INSURANCE INFORMATION

Dental Insurance Carrier	Dental Insurance Address City State Zip	
Dental Insurance Phone ( )	Dental Group #	Dental ID #
Subscriber's Name (First, Last) Subscriber's Date of Birth	Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse ☐ Partner	

EMERGENCY / CAREGIVER CONTACT

Name (First, Last)	Address City State Zip	
Home Phone ( )	Work Phone ( )	Cell Phone ( )
Relationship to Patient ☐ Partner/Spouse ☐ Parent/Guardian ☐ Other :	Other Information or Contact	Primary Spoken Language

SERVICE COORDINATOR / CARE MANAGER

Name of Service Coordinator/Care Manager (First, Last)	Work Phone ( )	E-Mail
Agency Name	Agency Address City State Zip	

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone ( )	Pharmacy Fax # ( )
Pharmacy Address	City	State Zip

ADDITIONAL INFORMATION REQUESTED *(Required Per Federal Guidelines)*

Veteran Status	Educational Level	Agriculture Work Status
☐ Veteran ☐ Non-Veteran	☐ High School ☐ AS College ☐ BS College	☐ Non Agricultural ☐ Seasonal ☐ Migrant

Citizenship		
☐ US Citizen by Birth ☐ US Citizen First Generation ☐ Immigrant ☐ Naturalized ☐ Permanent Resident or Alien ☐ Other	☐ Masters Degree ☐ Doctorate Degree ☐ None **Income Status** ☐ Unknown/Refused to Provide ☐ Patient has income	☐ Employee Year - Round ☐ Retired Farm Worker **Family Size** What is your family size?

INCOME INFORMATION

Source of Income
- ☐ Child Support
- ☐ Other
- ☐ Salary
- ☐ Salary 2
- ☐ Social Security

Type of Income
- ☐ W-2
- ☐ 1099
- ☐ Form 1040
- ☐ Paystub
- ☐ Employer Letter
- ☐ Other

Amount of Income $________________

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

Source of Income (if more than 1)
- ☐ Child Support
- ☐ Other
- ☐ Salary
- ☐ Salary 2
- ☐ Social Security

Type of Income
- ☐ W-2
- ☐ 1099
- ☐ Form 1040
- ☐ Paystub
- ☐ Employer Letter
- ☐ Other

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/Apartment ☐ OPWDD Residence/Supportive Living ☐ Public Housing ☐ Homeless

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

____

If you are experiencing homelessness, 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 Print Name________________________ Date __________

☐ Guardian/Caregiver Print Name________________________ Date __________

Updated: 2/24/25

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CENTER HEALTH CARE

#__________

Health History

Personal Information (Please print) **Today's Date**____/____/______

Indicate your main medical concern ______________________________

Name______________________________ **Age**_______ **Date of Birth** ____/____/______

Marital status: Single ☐ Married ☐ Separated ☐ Divorce ☐ Widow ☐ Birthplace______________________

Occupation______________________ Religion ______________________ How far did you go in school?________

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

Medical History

Diagnosis ☐ Developmental Disability ☐ Traumatic Brain Injury ☐ Autism

☐ Other______________________________

List allergies to medicines ______________________ Any other allergies? ______________________

Do you smoke? YES ☐ NO ☐ How much? ______________ For how many years? ________

Do you want to stop smoking? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

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

Do you want to stop? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

Are you on a special diet? YES ☐ NO ☐ ______________________________

List all your Medications & Prescribing Provider's Name (including those not needing a prescription)

Previous Hospitalizations (not including normal pregnancies)

Operation or Illness	Hospital / Doctor	Year

List the year you last had: (write NONE if never had)

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

Are you currently seeing any other providers/specialists? *Please list name and specialty.*

Check ✓ if you have ever had:

EARS		GI		Headaches		Blood Transfusion	
Hearing Impairment		Diverticulitis		Multiple Sclerosis		Breast Lump	
		Gall Bladder Disease		Neuropathy		Cervical Disorder	
ENT		Jaundice		Parkinson's Disease		Developmental Disability	
Gag Reflex Concerns		Ulcer		Seizure/Epilepsy		Diabetes (Specify type):	
Swallowing Disorder				Shunt (Cerebral)			
		GU		Strokes		Positive TB	
EYES		Kidney Disease		Traumatic Brain Injury		German Measles (Rubella)	
Cataracts		Urinary Infections		Tremors		History of Cancer (Specify):	
Glaucoma							
Vision Impairment		MUSCULAR SKELETAL		RESPIRATORY		Radiation/Chemotherapy:	
		Arthritis/Lupus		Asthma		☐ Current ☐ Past	
CARDIOVASCULAR		Fractures		Emphysema/COPD		Measles	
Valve Disorder		Gout		Hay Fever		Mumps	
Circulatory Problems		Joint Replacement (Specify):		Pneumonia		Organ Transplant (Specify):	
Elevated Cholesterol				Tracheostomy (Specify):			
Enlarged Heart				☐ Current ☐ Past		Rheumatic Fever	
Heart Attack		Osteoporosis				Sexually Transmitted Infection	
Heart Murmur				OTHER		Thyroid Disease	
High Blood Pressure		NEUROLOGICAL		ADHD		Sleep Apnea	
Low Blood Pressure		Cerebral Palsy		Autism			
		Dementia		Bladder Disorder			

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.

	NAME	AGE	Diabetes	Cancer	Heart Trouble	High Blood	Stroke	Mental Illness	BleedingTend	Kidney Disease	Age of Death	If Deceased, Cause of Death
Father												
Mother												
Brothers												
Sisters												
Spouse												
Children												

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CENTER HEALTH CARE

#____________

Dental History

> ***Please be aware that your first dental visit will consist of an evaluation by a Dentist and a full series of x-rays in order to determine an accurate treatment plan that will address your current state of dental health. Please bring a copy of any x-rays you may have had within the past year to your first visit.***

Dental Information (Please print)

Today's Date____/____/_____

Name______________________________ **Age**_____ **Date of Birth** _____/_____/_____

Date of last dental visit ________________

Name of Dental Office ______________________________

Address of Dental Office______________________________

Date of most recent dental cleaning and exam: ____________ (date); X-Rays __________ (date)

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

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

☐ Nitrous Oxide

☐ 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:

____

____

____

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CENTER HEALTH CARE

Consent to Treat & Patients' Bill of Rights

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, dental providers, psychologists, and therapists involved in the care of *(patient's name):*

____. To provide medical, clinical, or dental services, and perform such treatment, operations, or procedures that are necessary during the normal course of providing these services. Certain procedures may require an additional signed consent. This consent includes medical, clinical, and dental services provided through telehealth and telephonic platforms.

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 Center Health Care 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 Center Health Care, 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: 9/16/20

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient of Center Health Care at the Center for Disability Services, you have the right, consistent with law, to:

(1) Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor;

(2) Be treated with consideration, respect and dignity, including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consents prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center staff, the operator, and the New York State Department of Health without fear of reprisal;

(12) Express complaints about care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient and/or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may make a complaint to the New York State Department of Health's Office of Health;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release of disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except required by law or third party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law and Subpart 50-3. For additional information link to: https://www.health.ny.gov/publications/1449/section_1.htm#access;

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;

(17) When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center;

(18) View a list of the health plans and the hospitals that the center participates with; and

(19) Receive an estimate of the amount that you will be billed after services are rendered.

______________________________ ____________

Signature of Patient / Responsible Party   Date

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Center Health Care

AUTHORIZATION TO **OBTAIN & RELEASE** PROTECTED HEALTH INFORMATION

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

Print Patient Name & Address

Patient Name:______________________________ Phone: ( )__________________

Former/Maiden Name:__________________________ DOB:____/____/____

Address:____
Street City State Zip

Name of Agency Sending Records to CHC

I, ______________________________ hereby authorize ______________________________

Address:____
Street City State Zip

Phone: ( )____________________ Fax: ( )____________________

to disclose Protected Health Information (PHI) **TO**: **Provider Name** ______________________
Center Health Care
ATTN: Medical Records Department
314 So. Manning Blvd.
Albany, NY 12208
Phone: (518) 437-5710 Fax: (518) 437-5711

Indicate specific information to be disclosed

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

☐ 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.

SIGN AND DATE HERE

______________________________ ______________________________ ____/____/____
Signature of Patient or Legal Representative Relationship to patient/representative's authority Date

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CENTER HEALTH CARE

Hixny *Electronic Data Access Consent Form*

ONLY for Primary Care, Behavioral Health, or Neurology

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) checked off below** 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.

Print Name of Patient ____________________ Date of Birth ____________________ Date ____________________

Signature of Patient or Patient's Legal Representative ____________________ Print Name of Legal Representative (if applicable) ____________________

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*
•Birth control and abortion (family planning)
•Genetic (inherited) diseases or tests
•HIV/AIDS
•Mental health conditions
•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.

Revised: 4/9/19

Health Care Proxy

(1) I, ______________________________

hereby appoint ______________________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint ______________________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name ______________________________

Your Signature ______________________________ Date ______________

Your Address ______________________________

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ______________________________

____

☐ Limitations ______________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ______________________________ Date ______________

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date ______________

Name *(print)* ______________________________

Signature ______________________________

Address ______________________________

____

Witness 2

Date ______________

Name *(print)* ______________________________

Signature ______________________________

Address ______________________________

____

Department of Health