HUDSON HEADWATERS
HEALTH NETWORK

Today's Date: ____ / ____ / ______

HEALTH HISTORY QUESTIONAIRE

Name: ____ Date of Birth: ____ / ____ / ______
Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other ______________________
Gender Identity: ☐ Female ☐ Male ☐ Non-conforming (neither exclusively female or male)
☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male
☐ Choose not to disclose ☐ Other ______________________

Please take a few moments to answer these questions about your past medical history. This will help us to serve you better. This information will be kept **CONFIDENTIAL**. Thank you.

ALLERGIES: Please list any medication allergies, reactions, and other allergies.

____
____
____
____

MEDICATIONS: Please list any prescription, over-the-counter medications, herbals and/or vitamins you are taking. Include dose, frequency and prescribing provider.

____
____
____
____

IMMUNIZATIONS/VACCINES: Indicate year of your last.

Tetanus booster ________________________ Pneumonia vaccine ________________________
Flu shot (influenza) ________________________ TB skin test ________________________

MEDICAL ILLNESSES: Please list any hospitalizations or medical illnesses. Note year.

____
____
____
____

SURGERY: Please list any operations you have had. Note year and provider name.

____
____
____
____

Continue to Page 2 →

Name: ________________________
Date of Birth: ____ / ____ / ______

SOCIAL HISTORY:

Marital Status: ____________ Do you live alone? ☐ Yes ☐ No Do you have pets? ☐ Yes ☐ No
Number of children: ____________ Are you sexually active? ☐ Yes ☐ No Contraception? ☐ Yes ☐ No
Sexual Orientation: ☐ Homosexual ☐ Heterosexual ☐ Bisexual ☐ Other ______________________
☐ Choose not to disclose
Assigned sex at birth: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown

Are you currently employed? ☐ Yes ☐ No Retired/Disabled? ☐ Yes ☐ No If yes, date: ____________
If working, what is your occupation? ______________________________________

Do you have an Advance Directive (Living Will, Healthcare Proxy, DNR) on file? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, what type (smoke, chew, vape)? ____________
If yes, how many packs per day? ____________ Do you live with someone who smokes? ☐ Yes ☐ No
If not currently a smoker, did you smoke in the past? ☐ Yes ☐ No
If yes, what age did you start? ____________ What age did you quit? ____________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? ____________

Do you use recreational(street) drugs? ☐ Yes ☐ No If yes, what? _________________________

How much caffeine do you consume per day? ____________
Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Diabetic ☐ Other ____________________
Do you exercise regularly? ☐ Yes ☐ No

Are there guns in your home? ☐ Yes ☐ No If yes, are they secure? ☐ Yes ☐ No

Are there smoke and carbon monoxide detectors in your home? ☐ Yes ☐ No

FAMILY HISTORY: Please note their health status and age, or age at death and cause.

Mother: ____
Father: ____
Siblings: ____
Children: ____

OTHER DOCTORS YOUR SEE: Include reason.

____
____
____
____

PREVENTATIVE CARE: Indicate the year of your last, including provider's name.

Colorectal Screening (colonoscopy, fecal occult blood) ________________________________
Pap Smear ____
Mammogram ____
Bone Density (Dexascan) ____
Eye Exam ____
Dental Appointment ____

Hudson Headwaters Health Network

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

NEW YORK STATE DEPARTMENT OF HEALTH

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

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

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

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: ____________ until ____________

INSERT START DATE — INSERT EXPIRATION DATE OR EVENT

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

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

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

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

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

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

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

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

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

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

HUDSON HEADWATERS
HEALTH NETWORK

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand and have been provided with a copy of Hudson Headwaters Health Network Privacy Practices that provides a more complete description of how the Network may use and disclose my protected health information in accordance with state and federal regulations for privacy and security. I further understand that Hudson Headwaters Health Network reserves the right to change its privacy practices. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I, ____, date of birth ________________, understand that as part of my health care, Hudson Headwaters Health Network originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare options of the Network such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that Hudson Headwaters Health Network may send test results and correspondences associated with my care to the address I have provided. We may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental or billing items.

If you require a restriction on the above please see a staff member at the desk.

X____ **X**________________

Patient's Signature or Signature of Patient Representative Date

☐ Patient refused to sign.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to HHHN for medical services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co-pay (co- insurance, deductible) or other personal obligations at the time service is rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I give HHHN permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care, to those I have named below: (please note: Certain medical conditions may require a separate release.)

____

(please print first name, last name, and relationship)

Because Hudson Headwaters receives funding from the Federal Government we are required to collect information about income ranges. Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0 - $11,769	$11,770 - $17,654	$17,655 - $23,539	$23,540 +
2	$0 - $15,929	$15,930 - $23,894	$23,895 - $31,859	$31,860 +
3	$0 - $20,089	$20,090 - $30,134	$30,135 - $40,179	$40,180 +
4	$0 - $24,249	$24,250 - $36,374	$36,375 - $48,499	$48,500 +
5	$0 - $28,409	$28,410 - $42,614	$42,615 - $56,819	$56,820 +
6	$0 - $32,569	$32,570 - $48,854	$48,855 - $65,139	$65,140 +
7	$0 - $36,729	$36,730 - $55,094	$55,095 - $73,459	$73,460 +
8	$0 - $40,889	$40,890 - $61,334	$61,335 - $81,779	$81,780 +
9	$0 - $45,049	$45,050 - $67,574	$67,575 - $90,099	$90,100 +
10	$0 - $49,209	$49,210 - $73,814	$73,815 - $98,419	$98,420 +

☐ Patient refused to answer.

X____ X________________

Patient's Signature or Signature of Patient Representative — Date

☐ Patient refused to sign.

HHHN, HIXNY, Commonwell, and Carequality Fact Sheet

Details about patient information shared by Hudson Headwaters Health Network ("HHHN"), the CommonWell Health Alliance ("CommonWell"), Carequality, and the Health Information Xchange of New York ("HIXNY") and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by HHHN and Providers associated with CommonWell and Carequality 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.

Unless otherwise permitted by State and Federal law and if permitted by HIXNY, your electronic health information shall be disclosed, accessed and used by HHHN healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare 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.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all HHHN patients and members.

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.

2. **What Types of Information About You Are Included**. If you give consent, HHHN and authorized CommonWell and Carequality Providers may access ALL of your electronic health information available through CommonWell and Carequality and all employees, agents and members of the medical staff of HHHN 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	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• 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.**

3. **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 affiliated with HHHN is available from HHHN, at any time by checking HHHN's website at _HHHN.org_, or You can contact the HHHN Privacy Officer by writing to: HHHN, Privacy Officer, 9 Carey Road, Queensbury, NY 12804 or calling: 518-761-0300. A complete list of approved CommonWell and Carequality Providers are available at : https://www.commonwellalliance.org/who-is-connected/ and https://carequality.org/active-sites-search/. A complete list of current HIXNY Information Sources is available at any time by checking the HIXNY website at https://www.hixny.org/healthcare-community/partners/ or by **calling HIXNY at 518-640-0021.**

4. **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 the medical staff of HHHN or an approved CommonWell and/or Carequality Provider who are involved in your medical care; health care providers who are covering or on call for one of HHHN's doctors or a CommonWell and/or Carequality Provider's doctors; designated staff involved in quality improvement or care management activities; and staff members of HHHN or an approved CommonWell and/or Carequality Provider who carry out activities permitted by this Consent Form as described above in paragraph one.
5. **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, contact our Risk Management & Compliance Department at 518-761-0300 ext. 31314 or via email at patientconcerns@hhhn.org, contact one of the CommonWell and/or Carequality Providers you have approved to access your records; or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access to information about you has done so through HIXNY, call HIXNY at: **518-640-0021**; or visit HIXNY's website: http://www.hixny.org; or call the NYS Department of Health at 518-474-5423.
6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by HHHN or CommonWell and/or Carequality Providers 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. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through CommonWell and/or Carequality. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HHHN, HIXNY and persons, including CommonWell and/or Carequality Providers, who access this information through these health information exchanges must comply with these requirements.
7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time as HHHN ceases operation, whichever is later.
8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to HHHN. You can also change your consent choices by signing a new Consent Form at any time.

Note: Organizations, including CommonWell and/or Carequality Providers, that access your health information through CommonWell, Carequality, and/or 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.

9. **Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" 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 CommonWell and/or Carequality. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.
10. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**
11. **Risks of Denying Consent**. If you deny consent for HHHN and CommonWell and/or Carequality Providers to access your information through CommonWell and/or Carequality, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.

HHHN, HIXNY, COMMONWELL, AND CAREQUALITY CONSENT FORM

In this Consent Form, you can choose whether to allow Hudson Headwaters Health Network ("HHHN") health care providers and non-HHHN health care providers who may request access to your medical records for purposes of current treatment ("Providers") to obtain access to your medical records and/or health information through a computer network operated by the CommonWell Health Alliance ("CommonWell") and/or Carequality. In order to enable HHHN and other providers to know what information may be available about you through CommonWell and and/or Carequality, you must enroll in CommonWell and Carequality and verify the other providers where you were or are a patient. This can help your Providers collect the medical records you have in different places where you get health care, and make them available electronically to the Providers treating you. A complete list of approved CommonWell and Carequality Providers are available : https://www.commonwellalliance.org/who-is-connected/ and https://carequality.org/active-sites-search/.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of HHHN to see and obtain access to your electronic health records through HIXNY, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the Providers treating you. This consent also gives your permission for any HHHN program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through HIXNY. A complete list of current HIXNY Information Sources is available from HIXNY and can be obtained at any time by checking the HIXNY website at https://www.hixny.org/healthcare-community/partners/ or by **calling HIXNY at 518-640-0021.** Upon request, your provider will print this list for you from the HIXNY website.

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.**

HHHN and HIXNY share 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). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org. HHHN and other Providers also share information about people's health with CommonWell and Carequality to provide you with medical treatment and related services. To learn more about CommonWell and Carequality visit their websites at https://www.commonwellalliance.org or https://www.carequality.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL employees, agents and members of the medical staff of HHHN to access ALL of** my electronic health information through CommonWell **and Carequality** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of HHHN to access ALL of** my electronic health information through **HIXNY** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL employees, agents and members of the medical staff of HHHN to access** my electronic health information through **CommonWell, Carequality,** or **HIXNY** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" 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 CommonWell. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Print Name of Patient	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable) to Patient (if applicable)	Relationship of Legal Representative