

#### AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name		Da	Date of Birth Phone Number		er	
Street Address	City			State	Zip Code	
A) I hereby authorize records FROM: B)		B) To be released TO:				
Name: I		Name:				
Address: Ad		Address:				
		City/State/Zip:				
		Phone	Phone: Fax:			
C) Information disclosed: (please select one)		D) Special Considerations:				
Medical information  Dental information			To include the following information, please initial below. If not initialed, this information will not be disclosed.			
Entire record set			Alcohol/Drug treatment			
Date range: to			HIV/AIDS-related information			
Other:			Mental health treatment			
E) Purpose of requested information: (please select	ct one)					
□ At the request of the individual □ Transfer of care (select reason)						
Legal purposes     Patient experience     Other:						
Coordination of care  Patient relocation						
F) Delivery method: (please select one)						
US mail (Paper)         US mail (CD)         Pick up at:						
Encrypted email:      Fax to:						
G) Authorization Expiration: Unless previously revo event: *Please note: If left blank, t	-		ng, this authorization e upon the completion of the re	-		
H) If not the patient, name of person signing authorization:			uthority to sign on behalf of patient:			
In accordance with New York State Law and the Privacy Rule of the Health	Insurance Por	rtability a	and Accountability Act of 1	996 (HIPAA), I un	derstand that:	
This authorization may include disclosure of information relating to ALCOH RELATED INFORMATION only if I place my initials on the appropriate line any of these types of information, and I initial the line in the Special Conside	in the Special	Conside	erations section. In the eve	ent the health info	mation described above includes	
If I am authorizing the release of HIV-related, alcohol, or drug treatment, o without my authorization unless permitted to do so under federal or state law information without authorization. If I experience discrimination because of Human Rights at (212) 480-2493 or the New York City Commission of Hum	v. I understand f the release or	l that I ha r disclos	ave the right to request a li ure of HIV-related informa	st of people who n ation, I may conta	nay receive or use my HIV-related ct the New York State Division of	
I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the exten that action has already been taken based on this authorization.						
Signing this authorization is voluntary. My treatment, payment, enrollment in	a health plan	or aligibi	lity for bonofite will not bo a	conditioned upon r	ny authorization of this disclosure	

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.



# **GENERAL CONSENT AND AGREEMENT**

We have developed the following agreement to ensure a long and healthy relationship together. Please read the following information carefully. After you have read this consent and agreement, please sign your name indicating your acceptance of the terms of this agreement.

- I, \_\_\_\_\_, \_\_\_\_ agree to permit the providers and staff of (Patient's name) (date of birth)
- Hudson Headwaters Health Network (HHHN) to provide medical care to myself, child, or legal ward as applicable.
- I agree to permit laboratory and diagnostic tests, medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency care as necessary, and hospital services performed at the request of my provider or other providers assisting in my care. I understand that I have the right to refuse this treatment at any time.
- I understand that a medical record will be prepared and maintained about me by HHHN, and that I am able to view my medical record via the *Patient Portal*. I am also entitled to obtain a copy of my medical record by signing an *Authorization for Release of Health Information* form.
- I agree to abide by HHHN's Patient Responsibilities and understand that these responsibilities are posted in all health centers, online, and are physically available to me upon request. I understand that HHHN maintains the right to discontinue treatment for any violation of these responsibilities, such as failure to maintain a consistent appointment schedule or inappropriate behavior. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate medical care.
- I understand that some treatment and procedures may require an additional consent agreement to be completed.
- I understand that this consent is valid as long as I am an active patient of HHHN. I have the right to withdraw my consent at any time. I understand that refusal to sign this consent and agreement may prohibit my ability to access HHHN services.

By signing this document, you understand the agreement and consent in full, and you have had all of your questions answered to your satisfaction.

Signature of Patient or Representative Authorized by Law

Print Name



# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, \_\_\_\_\_, \_\_\_\_\_ hereby acknowledge that I have been offered a copy (date of birth)

of the Hudson Headwaters Health Network (HHHN) Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how HHHN may use and/or disclose my personal health information both with and without my authorization. I further understand that HHHN reserves the right to change its privacy practices at any time. 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 understand that as part of my health care, HHHN 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 HHHN such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that HHHN may send test results and correspondences associated with my care to the address I have provided. HHHN 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 front desk.

Signature of Patient or Representative Authorized by Law

Print Name



# **ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, \_\_\_\_, \_\_\_\_, (Patient's name) (date of birth)

\_ 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 the Network for medical services rendered to myself and/or my dependents.

I request that payment of authorized medical benefits is made on my behalf directly to Hudson Headwaters Health Network (HHHN). I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by HHHN and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

I understand that refusal to sign this form prohibits Hudson Headwaters Health Network from billing my health care insurer and that I will be personally responsible for any charges associated with any service(s) rendered.

This assignment will remain in effect until revoked by me in writing and is not invalidated by any changes in my health care insurance plan or health care insurer. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Representative Authorized by Law

Print Name



Ι,

Patient or Legal Representative refused to sign/complete this document.

# AUTHORIZATION TO RELEASE BILLING INFORMATION

(Patient's name), (date of birth)

\_\_\_\_ authorize the release of any medical or other

information necessary to my health care insurer(s) in order to process any claims associated with services that I have received from Hudson Headwaters Health Network (HHHN).<sup>1</sup>

Furthermore, I authorize payment of medical benefits to HHHN from my health care insurer(s) for any claims associated with services that I have received from HHHN.<sup>2</sup>

I understand that my refusal to sign this form may prevent my health care insurer(s) from paying HHHN for my services. I understand that I will be personally responsible for any charges associated with any service(s) rendered if this occurs.

Signature of Patient or Representative Authorized by Law

Print Name

<sup>&</sup>lt;sup>1</sup> This is a requirement of CMS 1500 form, box 12.

<sup>&</sup>lt;sup>2</sup> This is a requirement of CMS 1500 form, box 13.



# **RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_\_\_ give Hudson Headwaters Health Network (HHHN) (date of birth)
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<sup>1</sup>, to those I have named below:

		OB/GYN
		Specialty care:
		All information
(First and last name)	(Relationship to patient)	-
		Primary care
		OB/GYN
		Specialty care:
		All information
(First and last name)	(Relationship to patient)	-
		Primary care
		OB/GYN
		Specialty care:
		All information
(First and last name)	(Relationship to patient)	-
		Primary care
		OB/GYN
		Specialty care:
		☐ All information
(First and last name)	(Relationship to patient)	-

I understand that this document **does not** expire and is considered to be in effect unless I update or revoke it in writing. Furthermore, this document only applies to medical-related information and does not include the release of dental information.

I understand that my refusal to sign this form and/or refusal to designate a person above prohibits HHHN from disclosing my general condition (i.e., upcoming appointment date) to anyone besides myself.

Signature of Patient or Representative	
Authorized by Law	

Print Name

<sup>&</sup>lt;sup>1</sup> This **does not** include information relating to family planning services (i.e. birth control, contraception), sexually transmitted infection testing or treatment, and HIV testing or treatment for patients under the age of 18. This information is only released directly to the patient.



# DETERMINATION OF FAMILY SIZE AND INCOME

The Network serves all patients and does not deny services based on patients' ability to pay. The Network also offers discounted fees for patients who qualify for our sliding fee program. Because the Network receives funding from the Federal Government to offer these services, we are required to collect income range information for all patients.

#### Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1:	CATEGORY 2:	CATEGORY 3:	CATEGORY 4:
1	\$0-15,060	\$15,061-22,590	\$22,591-30,120	\$30,121
2	\$0-20,440	\$20,441-30,660	\$30,661-40,880	\$40,881
3	\$0-25,820	\$25,821-38,730	\$38,731-51,640	\$51,641
4	\$0-31,200	\$31,201-46,800	\$46,801-62,400	\$62,401
5	\$0-36,580	\$36,581-54,870	\$54,871-73,160	\$73,161
6	\$0-41,960	\$41,961-62,940	\$62,941-83,920	\$83,921
7	\$0-47,340	\$47,341-71,010	\$71,011-94,680	\$94,681
8	\$0-52,720	\$52,721-79,080	\$79,081-105,440	\$105,441

*Please note:* this table is based on Federal Poverty Guidelines (FPG) which are released every year. This formmust be **updated** and **completed** annually in accordance with Uniform Data System requirements.

Signature of Patient or Representative Authorized by Law Print Name