HUDSON HEADWATERS HEALTH NETWORK

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

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, residents**,** learners and staff of 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 providers, residents or others assisting in my care. I understand that I have the right to refuse this treatment at any time.
- I understand that my care team may include resident physicians, students, or other trainees. A resident is a doctor who has graduated from medical school and is undergoing further training. I understand that the resident may perform all or parts of my care. I understand that I have the right to refuse this arrangement 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 my provider leverages technological tools and resources including those which leverage artificial intelligence in the delivery of my 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	Date

HUDSON HEADWATERS HEALTH NETWORK

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, _____ hereby acknowledge that I have been offered a copy
(Patient's name) *(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	Date

HUDSON HEADWATERS HEALTH NETWORK

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ASSIGNMENT OF BENEFITS

I, _____, _____ understand that my health information may be used
(Patient's name) *(date of birth)*
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	Date

HUDSON HEADWATERS
HEALTH NETWORK

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

AUTHORIZATION TO RELEASE BILLING INFORMATION

I, _____, _____ authorize the release of any medical or other
(Patient's name) *(date of birth)*
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). [1]

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. [2]

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	Date

[1] This is a requirement of CMS 1500 form, box 12.
[2] This is a requirement of CMS 1500 form, box 13.

HUDSON HEADWATERS HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number

Street Address	City	State	Zip Code

A) I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

B) To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) Information disclosed: *(please select one)*

☐ Medical information ☐ Dental information

- -

☐ Entire record set

☐ Date range: _____ to _____

☐ Other: _____

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select 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 revoked by me in writing, this authorization will expire on the following date or event: _____ *Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.

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 extent that action has already been taken based on this authorization.

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.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date

HUDSON HEADWATERS HEALTH NETWORK

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

RELEASE OF MEDICAL INFORMATION

This document only applies to medical-related information and does not include the release of dental information.

Refusal to complete this form prohibits Hudson Headwaters Health Network from disclosing general information including date and time of appointments unless authorized under law.

I,_____, _____give Hudson Headwaters Health Network (HHHN)
(Patient's name) *(date of birth)*

permission to disclose my location, condition and other information regarding my care to those I have named below.

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ *OB/GYN/Family Planning (**Minor can consent**)
☐ Specialty care: _____
☐ **All information**

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ *OB/GYN/Family Planning (**Minor can consent**)
☐ Specialty care: _____
☐ **All information**

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ *OB/GYN/Family Planning (**Minor can consent**)
☐ Specialty care: _____
☐ **All information**

I understand that this document **does not** expire and will remain in effect unless updated or revoked in writing. I will report any concerns I may have regarding my personal health information to Hudson Headwaters Health Network by calling 518.409.8642 or emailing patientconcerns@hhhn.org .

***OB/GYN/Family Planning:** I understand by checking OB/GYN/Family Planning, this includes information relating to family planning services (i.e. birth control, contraception), sexually transmitted infection testing or treatment, unless prohibited by law. In NYS, those under the age of 18 have the right to confidentially access these services via their own consent.

_____ _____ _____
Signature of Patient or Representative Print Name Date

Attention Staff: It is important to note that the patient could be able to consent to some but not all care. For instance, a minor patient seeking treatment for STI can consent and direct the release of information regarding that care, however their primary care records are released under the authority of the parent or legal guardian. Please reference the Consent for the Treatment of Minors policy or contact the Risk and Compliance team.

Hudson Headwaters Health Network complies with all applicable laws regarding the release and disclosure of personal health information, including HIPAA, and the New York State (NYS) Public Health Law §2504 regarding the Treatment of Minors.

HUDSON HEADWATERS HEALTH NETWORK

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

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.

Patient Name: _____ **Patient Date of Birth:** _____

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0-15,650	$15,651-23,475	$23,476-31,300	$31,301
2	$0-21,150	$21,151-31,725	$31,726-42,300	$42,301
3	$0-26,650	$26,651-39,975	$39,976-53,300	$53,301
4	$0-32,150	$32,151-48,225	$48,226-64,300	$64,301
5	$0-37,650	$37,651-56,475	$56,476-75,300	$75,301
6	$0-43,150	$43,151-64,725	$64,726-86,300	$86,301
7	$0-48,650	$48,651-72,975	$72,976-97,300	$97,301
8	$0-54,150	$54,151-81,225	$81,226-108,300	$108,301

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

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date

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)	Relationship of Legal Representative
to Patient (if applicable)	