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.

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 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

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

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

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

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.

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☐ 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 (**Minor can consent**)
☐ Specialty care: _____
☐ **All information**

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

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

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

☐ Primary care
☐ *OB/GYN (**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:** I understand by checking OB/GYN, 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.

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 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