325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Michael W. Cole, LCSW, Director of Community Services
Daniel S. Almasi, LCSW-R, Deputy Director / Director of Clinical Services

Welcome to Columbia County Mental Health Center

Congratulations on taking this first step toward better mental health. We thank you for choosing Columbia County Mental Health Center as your mental health provider. We understand that asking for help can be a difficult choice and many people are hesitant to seek counseling. We commend you for making the choice to pursue a path of wellness and recovery intended to improve your health and emotional well being.

The staff members of Columbia County Mental Health Center are New York State licensed behavior health professionals who are committed to working with you to create a customized care plan to address your needs. Our purpose is to create a warm and compassionate environment where you will feel accepted, cared for, and comfortable expressing yourself. You can expect to be treated with respect and dignity by all staff, both administrative and clinical. We strive to provide the highest quality care possible and encourage you to let us know if you are not satisfied with your services or have any concerns or suggestions about your treatment.

Please review the attached information and return completed forms to the reception desk. If you have any questions when completing these forms, please feel free to ask for assistance. During your visit with us today you can expect to be seen by a Clinician as well as a Nurse, and that this process can take anywhere from one to two hours. We appreciate your patience as we work to attend to everyone visiting the Clinic today.

Remember, the most important factor in achieving success with your mental health is persisting until you have met your goals. Once again, thank you for allowing us to be part of your recovery.

Warmly,

Daniel S. Almasi, LCSW
Director of Clinical Services

Columbia County
Mental Health Center

Wellness Questionnaire

Today's Date:________________

Client's First & Last Name: ____

Date of Birth:___________ Age: ________

Referred here by: ____

Why are you seeking treatment? ____

____

____

What are your symptoms *(please check all that applies)*?

______	anxiety	_______	depressed/sad	_____	appetite/weight changes
______	panic attacks	_______	crying frequently	_____	sleep disturbance
______	hearing voices	_______	hopelessness	_____	repetitive behaviors
______	fear/phobia	_______	racing thoughts	_____	irritable/moody
______	mania	_______	feel "on edge"	_____	low energy/fatigue
______	low self-esteem	_______	poor concentration	_____	difficulty making decisions
______	lack of enjoyment	Other:	______________________________		

When did these symptoms begin?____

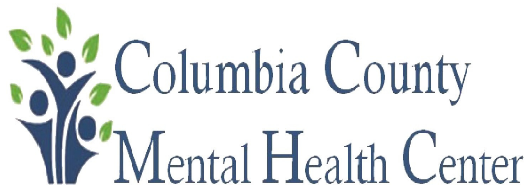
____

____

What do you think would help you? ____

____

____



Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	**DOB:**
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Twin County Recovery Services, Inc.
350 Power Avenue
Hudson, NY 12534
Telephone: (518) 828-9300 Fax: (518) 828-4712

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs ☐Financial/Billing ☒Admission/Assessment ☒Progress Notes ☒Service Plan ☒Diagnosis ☒Lab Results ☒History and Physical ☒Psychiatric Evaluations ☒Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information ☒Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*_______________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client : ____________________________ **Date: ___/___/___**

Signature of Person Acting for Client : ____________________________ **Date: ___/___/___**

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /

Provide the individual served with a copy Place the original in the service record

Columbia County Mental Health Center

Client Information

Client's Name (First-Last-Middle) ______________________________

Date of Birth ______________ Age ______ Sex ______ Social Security # ______________

Responsible Party if Client is a Minor ______________________________

Physical Address: Street ______________________ City __________ State ______ Zip ______

Mailing Address (if different than Physical) ______________________________

Town of ______________________ Is Patient a Columbia County Resident? Yes ☐ No ☐

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________________ Email Address ______________________

Insurance Information

Primary Insurance Company Name ______________________________

Please Circle HMO PPO Other ______________________________

Policy ID Number ______________ Group Number ______________ Phone ______________

Name of Insured ______________________ Insured Date of Birth ______________

Relationship of Insured to Client ______________________________

Secondary Insurance Company Name ______________________________

Please Circle HMO PPO Other ______________________________

Policy ID Number ______________ Group Number ______________ Phone ______________

Name of Insured ______________________ Insured Date of Birth ______________

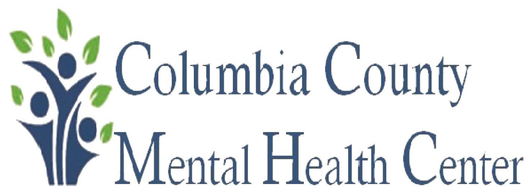
Relationship of Insured to Client ______________________________

YOU MUST PROVIDE INSURANCE INFORMATION TO ESTABLISH YOUR CO-PAY. IF YOU DO NOT HAVE INSURANCE, YOU MUST PROVIDE DOCUMENTATION OF INCOME TO DETERMINE YOUR FEE. IF YOU DO NOT PROVIDE INSURANCE OR INCOME INFORMATION, YOU WILL BE CHARGED THE FULL COST OF SERVICE. FAILURE TO PAY MAY RESULT IN A REDUCTION OF SERVICES.

I request that payment of authorized benefits be made on my behalf to Columbia County Mental Health Center for services furnished to me by the provider. I authorize Columbia County Mental Health Center to release to the above insurance carriers, Medicaid or Medicare any medical or other information necessary to process my insurance claims.

____

Signature of Client *(or legal representative if client is a minor)* Date



Notice of Privacy Practices

This notice describes the privacy practices of the Columbia County Department of Human Services/Mental Health Center (hereafter referred to as CCDHS/MHC) and the privacy rights of the people we serve. It will describe how information about you may be used and disclosed and how you can get access to this information.
The Health Insurance Portability and Accountability Act (HIPAA) Privacy rule DOES NOT CHANGE the way you get services from CCDHS/MHC, or the privacy rights you have always had under federal and state laws. The Privacy rule adds some details about how you can exercise your rights.

PLEASE REVIEW THIS NOTICE CAREFULLY.

CCCCDHS/MHC privacy commitment to you: CCCCDHS/MHC provides many different services to you. We understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. CCCCDHS/MHC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This notice tells you how CCDHS/MHC uses and discloses information about you. It describes your rights and what CCDHS/MHC responsibilities are concerning information about you. When we use the word "you" in this Notice, we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may mean your guardian, your health care proxy, or your involved parent, spouse, or involved adult family member. If you have questions about any part of this Notice of Privacy Practices (hereafter referred to as the Notice) or if you want more information about the privacy practices at DHS/MHC, please contact: *Ron Caponera, Corporate Compliance Officer/Privacy Officer, 401 State St., Hudson, New York 12534, (518) 828-8561.*

Who will comply with this Notice: All people who work for CCDHS/MHC will comply with this Notice. This includes employees, persons CCDHS/MHC contracts with who are authorized to enter information in your record or need to review your record to provide services to you, and volunteers who CCDHS/MHC allows to assist you.

What information is protected: All information that we create or keep that relates to your health or care and treatment, including but not limited to: your name, address, birth date, social security number, your medical information, your service or treatment plan, and other information about your care in our programs (including photographs or other images) is considered protected information. In this Notice, we refer to protected information as protected health information or "PHI". We create and collect information about you and we keep a record of the care and services you receive though this agency. The information about you is kept in a record; it may be in the form of paper documents in a chart or on a computer. We refer to the information that we create, collect, and keep as a "record" in this Notice.

Your health information rights: Unless otherwise required by law, your record is the physical property of CCDHS/MHC, but the information in it belongs to you and you have the right to have your information kept confidential. You have the following rights concerning your PHI:

- You have a right to see or inspect your PHI and obtain a copy of the information. Some exceptions apply, such as information compiled for use in court or administration proceedings. NOTE: CCDHS/MHC requires you to make your request for records in writing to the Privacy Officer. You may request copies in paper format or in an electronic form such as a CD, portable device, or memory stick. In some instances, we may charge you for copies.
- If we deny your request to see your information, you have the right to request a review of that denial. The Director/designee will appoint a licensed health care professional to review the record and decide if you may have access to the record.

- You have the right to ask CCDHS/MHC to change or amend information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by CCDHS/MHC or if after reviewing your request, we believe the record is accurate and complete.

- You have the right to request a list of the disclosures that CCDHS/MHC has made of your PHI. The list, however, does not include certain disclosures, such as those made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations, and disclosures to involved family. CCDHS/MHC, however, is not required to agree to your request.
- You have the right to request that CCDHS/MHC communicates with you in a way that will help keep your information confidential. You may request alternate ways of communication with you or request that communications are forwarded to alternative locations.
- You have the right to limit disclosures to insurers if you have paid for the service completely out of pocket.
- You will be notified if there is a breach of unsecured PHI containing your information; we are required by federal law to provide notification to you.
- We will require you to submit your requests in writing to the Privacy Officer. To request access to your clinical information or to request any of the rights listed here, you may contact *Ron Caponera, Corporate Compliance Officer/Privacy Officer, 401 State St., Hudson, New York 12534, (518) 828-8561.*

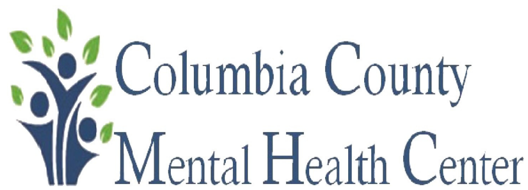
NOTE: Other regulations may restrict access to HIV/AIDS information, federally protected education records, and federally protected drug and alcohol information. See any special authorizations or consent forms that will specify what information may be released and when, or contact the Privacy Officer listed above.

Our responsibilities to you: We are required to:

- Maintain the privacy of your information in accordance with federal and state laws.
- Give you this Notice that tells you how we will keep your information private.
- Tell you if we are unable to agree to a limit on the use or disclosure that you request.
- Carry out reasonable requests to communicate information to you by special means or at other locations.
- Get your written permission to use or disclose your information except for the reasons explained in this Notice.
- We have the right to change our practices regarding the information we keep. If practices are changed, we will tell you by giving you a new Notice.

How CCDHS/MHC uses and discloses your health information: CCDHS/MHC may use and disclose information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- **Treatment:** CCDHS/MHC will use your information to provide you with treatment and services. We may disclose information to doctors, nurses, psychologists, social workers, and other CCDHS/MHC personnel, volunteers, or interns who are involved in providing your care. For example, involved staff may discuss your information to develop and carry out your treatment or service plan and other CCDHS/MHC staff may share your information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your information to other providers outside of CCDHS/MHC who are responsible for providing you with services.
- **Payment:** CCDHS/MHC will use your information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid, or other government agencies. For example, we may need to provide your health care insurer with information about the services you received in our agency or through one of



our programs so they will pay us for the services. In addition, we may disclose your information to receive prior approval for payment for services you may need.

Health Care Operations: CCDHS/MHC will use clinical information for administrative operations. These uses and disclosures are necessary to operate CCDHS/MHC programs and to make sure all individuals receive appropriate,

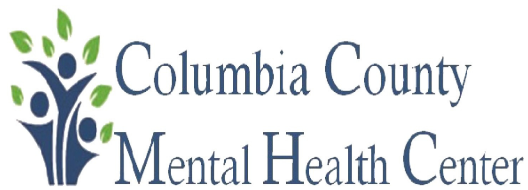
quality care. For example, we may use information for quality improvement to review our treatment and services and to evaluate the performance of our staff in serving you.

We may also disclose information to clinicians and other personnel for on-the-job training. We will share your health information with other CCDHS/MHC staff for the purposes of obtaining legal services from our attorneys, conducting

fiscal audits, and for fraud and abuse detection and compliance through our Compliance Program. We may also disclose information to our business partners who need access to the information to perform administrative or professional services on our behalf.

Other uses and disclosures that do not require your permission: In addition to treatment, payment, and health care operations, CCDHS/MHC will use your information without your permission for the following reasons:

- When we are **required to do so by federal or state law**.
- For **public health reasons**, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease.
- To report **domestic violence and adult abuse or neglect** to government authorities if necessary to prevent serious harm.
- For **health oversight activities**, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject.
- For **judicial and administrative proceedings**, including hearings and disputes. If you are involved in a court or administrative proceeding we will disclose information if the judge or presiding officer orders us to share the information.
- For **law enforcement purposes**, in response to a court order or subpoena, to report a possible crime, to identify a suspect or witness or missing person, to provide identifying data in connection with a criminal investigation, and to the district attorney in furtherance of a criminal investigation of client abuse.
- Upon your death, to **coroners or medical examiners** for identification purposes or to determine cause of death, and to **funeral directors** to allow them to carry out their duties.
- To organ procurement organizations to accomplish cadaver, eye, tissue, or **organ donations** in compliance with state law.
- For **research** purposes when you have agreed to participate in the research and the Privacy Oversight
- Committee has approved the use of the clinical information for the research purposes.
- To **prevent or lessen a serious and imminent threat** to your health and safety or someone else's.
- To authorized federal officials for intelligence and other **national security** activities authorized by law or to provide **protective services to the President** and other officials.
- To **correctional institutions** or **law enforcement officials** if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution.



- To **governmental agencies that administer public benefits** if necessary to coordinate the covered functions of the programs.

<u>Uses and disclosures that require your agreement</u>: CCDHS/MHC may disclose information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To **family members and personal representatives** who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location.

- To **disaster relief organizations** that need to notify your family about your condition and location should a disaster occur.

- For **fundraising** purposes, we may disclose information to a charitable program that assists us in fundraising with your permission. You have the right to refuse or opt out if you previously agreed to communications regarding fundraising.
- For **marketing** of health-related services, we will not use your health information for marketing communications without your permission.
- To disclose **psychotherapy** notes.

<u>Authorization required for all other uses and disclosures</u>: For all other types of uses and disclosures not described in this Notice, CCDHS/MHC will use or disclose information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for the sale of PHI and use and disclosure for marketing purposes, such as agency newsletters and press releases.
Note: If you cannot give permission due to an emergency, CCDHS/MHC may release information in your best interest. We must tell you as soon possible after releasing the information. You may revoke your authorization at any time. If you revoke your authorization in writing we will no longer use or disclose your information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revoked and we must retain information that indicates the services we have provided to you.

<u>Changes to this Notice</u>: We reserve the right to change this Notice. We reserve the right to make changes to terms described in this Notice and to make the new Notice terms effective to all information that CCDHS/MHC maintains. We will post the new Notice with the effective date in our facilities. In addition, we will offer you a copy of the revised Notice at your next scheduled service planning meeting.

<u>Complaints</u>: If you believe your privacy rights have been violated you can file a complaint with the:

- CCDHS/MHC Privacy Officer, Ron Caponera;
- Director of Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, (877) 696-6775; or,
- Office of Civil Rights by calling or writing Region II – US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278, Voice Phone (800) 368-1019, FAX (212) 264-3039, TDD (800) 537-7697.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT RECEIPT

I hereby acknowledge that I have reviewed and been offered a printed copy of **Columbia County Department of Human Services/Mental Health Center's** Notice of Privacy Practices.

Client Signature (*or legal representative if client is a minor*) Date

Print Name Phone number

If acknowledgement signed by client's legal representative, please indicate relationship to client:

- Parent or guardian of individual
- Health Care Proxy or Agent
- Beneficiary or personal representative of deceased individual
- Other

Name of Client (*if client is a minor*)

***For Office Use Only*:**

If client refuses to sign this Acknowledgment, document their reasons for refusal:

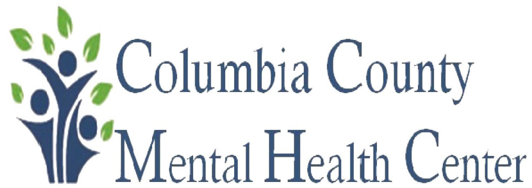
- Client declined to give a reason

and note the following:

- Client was offered a printed copy of this Notice of Privacy Practices
- Client was offered assistance in reading and/or understanding this Notice
- An offer was made to contact the Privacy Officer to explain this Notice

staff initials *date*

325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Michael W. Cole, LCSW, Director of Community Services
Daniel S. Almasi, LCSW-R, Deputy Director / Director of Clinical Services



Financial Agreement between Columbia County Department of Human Services/Mental Health Center and

Client's Name   Date of Birth

The staff at Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC) respects and assures your rights to privacy, confidentiality and dignity of treatment at all times.

The mission of CCDHS/MHC is to foster the health and welfare of residents of Columbia County by providing mental health services to adults, children and families especially to those who have no other provider options.

The staff at CCDHS/MHC will keep scheduled appointments, except in the case of an emergency or illness. If cancellation is necessary, CCDHS/MHC will attempt to do so 24 hours in advance of the scheduled appointment.

The staff at CCDHS/MHC works as a multi-disciplinary team and may consult amongst one another to develop an appropriate course of treatment for each client.

Clients may be asked to sign "Authorization to Use or Disclose Protected Health Information" consents so that CCDHS/MHC can obtain information from other sources and/or providers. However, in the event of an emergency, information may be provided to the emergency contacted listed in this Agreement, without the client's consent and/or to other appropriate providers/agencies deemed necessary concerning such emergency.

CCDHS/MHC will attempt to ensure client's appointments begin promptly.

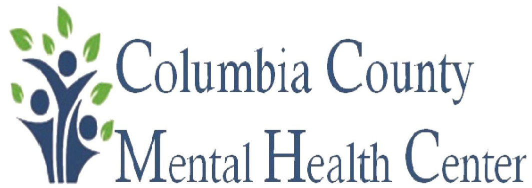
The work of CCDHS/MHC is funded through insurance reimbursements and client fees which are a critical source of income supporting the continuation of our purpose.

Client's failure to uphold financial responsibility impacts CCDHS/MHC's ability to provide services to others.

Payment for service is due at the time of service. Co-pays are due for *each* service on a given day. Cash, check, MasterCard/Visa and Discover are acceptable forms of payment. If paying by credit card, there is a fee of 2.35% plus $1.00 automatically added to the amount being charged. This fee is imposed by the banking/credit card industry and is not kept by CCDHS/MHC. This fee is subject to change.

It is the client's responsibility to know the level of coverage for services any payment by their insurance company. The client is responsible for any amounts not covered by their plan.

If the insurance plan requires a referral, the client is responsible for working with the insurance company and with CCDHS/MHC to ensure that this is in place. If CCDHS/MHC is an **in-network provider** with the insurance plan, co-pay is expected at time of service.



As an **in-network provider,** CCDHS/MHC will bill the insurance company for reimbursement. If CCDHS/MHC's charges apply to the client's deductible, or are not covered by the insurance plan, the client is responsible for any unpaid amounts.

It is the client's responsibility to notify CCDHS/MHC of any changes in insurance. Failure to notify CCDHS/MHC of changes in insurance *does not* alleviate the client's responsibility for full payment of services rendered. CCDHS/MHC reserves the right to discontinue contracting with insurance providers with 30 days advanced notice.

There are some services that CCDHS/MHC may provide to you that may not be covered by your insurance plan or may incur co-pay such as drug/alcohol screenings, court testimony, reports, copies of medical records, etc. Should you require these services; fees will be discussed with you. Co-pays are determined by your insurance company. In order to release your medical records outside of this agency, you will be required to sign an approved release of information form.

For clients who are not eligible for insurance for which proof has been provided, CCDHS/MHC offers a sliding fee scale. You will be asked to complete a fee sheet and bring in specific documentation such as pay stubs or tax returns to verify your source(s) of income. CCDHS/MHC will apply that information to an approved fee chart and determine your financial responsibility. You will be notified by the CCDHS/MHC Billing Department once this fee is established. Please note that this fee applies to each and every session including individual, group, and family therapy sessions. This fee will also apply whenever you see one of CCDHS/MHC's prescribers**.** Eligibility for remaining on the sliding scale will be reviewed every 6 months and you will be asked to provide updated information. ***For Medicaid pending clients you must provide proof from the Department of Social Services of your pending status.***

It is understood that it is the policy of CCDHS/MHC that:

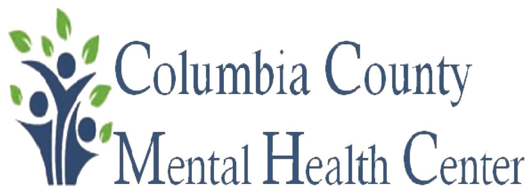
1) A $10.00 "no show fee" will be charged to clients for any missed appointment and any appointment NOT cancelled and/or rescheduled before 4 pm the day before the clients scheduled appointment. Insurance companies do not pay this fee. I understand that a pattern of missed or cancelled appointments will be interpreted as a lack of readiness to commit to therapy and further appointments may not be afforded to you.

2) Fees incurred for returned bank checks, for any reason, are the client's responsibility.

3) If services are rendered at a school satellite, any co-pays or other fees due will be billed to the responsible party listed in the chart.

4) If you have not been active in treatment for three (3) months or have failed to pay for services, your case may be closed. Your case may remain open if it is clinically indicated and is approved by your clinician's supervisor. If you wish to return after you have been discharged from treatment, you are welcome to call and request a new intake appointment. **Any money owed to the CCDHS/MHC must be paid in full, or a repayment plan must be established.**

5) **As previously noted all insurance co-pays, deductibles and sliding scale fees and any other fees that might be incurred by securing services at CCDHS/MHC are expected to be paid in full and always at the time of service.** If you incur a financial hardship and are having difficulty in meeting your financial obligation, please ask to speak to the engagement specialist. All reviews of financial hardship concerns will be conducted on a case by case basis, and any



payment plan will remain your responsibility until your financial obligation is met. **Non-compliance with your payment plan may affect the level of services you receive.**

Crisis services are available 24 hours a day to anyone in Columbia County regardless of participation in our services. If you feel you are at immediate risk of harm, ask to speak with a crisis screener. Crisis screeners are available in person or on the phone during clinic business hours; or if the clinic is closed, can be reached by calling the main clinic phone number, 518-828-9446.

Please Note: CCDHS/MHC utilizes the PMP (Prescription Monitoring Program) at admission as part of the assessment process to get a complete picture of the individual's medication profile. It may also be used periodically throughout the treatment process. The PMP is a registry of all controlled substances prescribed for individuals in New York. Use of the PMP is required prior to writing or filling any prescription for a controlled substance in the State of New York. Other states have similar databases, and those will be consulted if necessary. If you have any questions about this issue please contact our Medical Director, Carlos Valle, MD.

I understand that I am responsible for all charges and fees. I give CCDHS/MHC permission to release any information, including psychotherapy notes that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. If CCDHS/MHC is an in-network provider for my insurance plan, I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid directly to CCDHS/MHC. This assignment or a photocopy hereof is acceptable.

I have read and understand the above policies. To the best of my knowledge, I certify that all financial and insurance information that I have provided is accurate and complete and I will inform CCDHS/MHC of any change(s) in my circumstances.

Signature of Client *(or legal representative if client is a minor)* Date

---

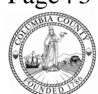
Witness Date

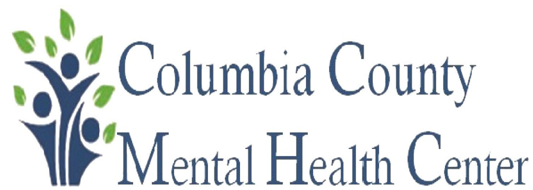
Clinic Use Only:

Client/Legal Representative received copy of this Agreement:

☐Yes ☐No *(declined)*

Date__________ Staff Initials__________





Emergency Contact Information

IMPORTANT
At times Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC) may need to speak with someone you choose regarding an emergency and/or a non-emergency situation. An emergency would be a situation where your well being and/or the well being of someone else are at risk. A non-emergency would be a situation where CCDHS/MHC have questions and/or concerns about your attendance and/or may need to obtain updated contact information so that we can reach you. Your emergency/non-emergency contact can be the same person if you choose.
You may cancel (revoke) your permission for us to speak to your emergency and/or non-emergency contact at any time by notifying us in writing.
Your permission for us to speak with your emergency and non-emergency contacts will automatically end when you are no longer receiving services and have been discharged from the clinic.

Signature of Client *(or legal representative if client is a minor)* **Date**

Emergency Contact

Name/First/Last/Middle Relationship

Address City State Zip

Home Phone Cell Phone Work Phone

Non-Emergency Contact

Name/First/Last/Middle Relationship

Address City State Zip

Home Phone Cell Phone Work Phone

Clinic Use Only - Revoked Date:

IN CASE OF A BUILDING EMERGENCY:
The Human Services Building at 325 Columbia Street, Hudson, NY, has a *Building Wide Emergency Management Plan* which addresses procedures to be followed in the event of various emergency type situations. The CCDHS/MHC has emergency policies and procedures specific to the third floor. These policies are available upon request.

325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Michael W. Cole, LCSW, Director of Community Services
Daniel S. Almasi, LCSW-R, Deputy Director / Director of Clinical Services

The Columbia County Mental Health Clinic (CCMHC) is committed to offering its clients the most comprehensive level of care possible. This means we believe in compassionate care that addresses all of your needs. We know that life circumstances such as physical health, employment, education, financial situations and substance use can have a major influence on the wellness and recovery that a client experiences during their treatment. The better we understand your needs and life circumstances, the better the outcome you are likely to have from treatment.

The process of understanding your needs starts with what is known as the Comprehensive Assessment. The Comprehensive Assessment is how the therapist will come to understand your specific needs. This assessment usually consists of a therapist asking questions about different aspects of your history. In addition, the CCMHC uses written screening tools such as the CRAFFT, Simple Screening Instrument for Substance Abuse and a tobacco screen to see if you might have additional needs. Research has shown that as many as 40-50% of people seeking mental health services also struggle with substance abuse. A large number of people go untreated because no one ever thought to ask them about their alcohol or drug use. The CCMHC believes that it's important to ask all clients about their drinking or drug use patterns. By doing this we can create the most appropriate treatment plan possible. We utilize a screening tool called the Simple Screening instrument for Substance Abuse for adults and the CRAFFT for children ages 11-17. Some clients may also be offered an oral fluid test which will test for the presence of alcohol and specific drugs.

Currently, the CCMHC uses Quest Diagnostics as its laboratory for processing fluid test results. Costs associated with the test are billed directly through Quest Diagnostics. Clients who are under a Managed Medicaid policy may be required to pay a laboratory co-pay. If you have questions or concerns please contact your insurance company directly to ask about your coverage.

325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Michael W. Cole, LCSW, Director of Community Services
Daniel S. Almasi, LCSW-R, Deputy Director / Director of Clinical Services

Dear Client:

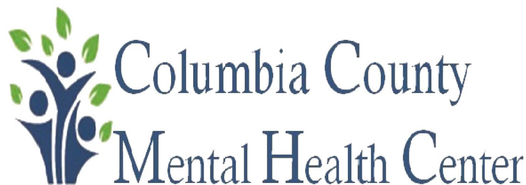
New York State Public Health Law requires most prescribers of controlled substances to consult New York State's online Prescription Monitoring Program (PMP) Registry through the Health Commerce System (HCS) when writing prescriptions for certain controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. Please note other states have similar databases which may also be accessed if necessary.

Columbia County Mental Health Center prescribers are required to access the PMP Registry prior to writing any prescription for a controlled substance for their clients. This is part of the assessment process and will allow the prescriber to better evaluate an individual's medication treatment plan. The PMP Registry may also be accessed periodically throughout the client's treatment process.

We appreciate your understanding and cooperation with this initiative. If you have any questions about the PMP and this policy, please ask a member of the clinic's nursing staff.

Sincerely,

Daniel S. Almasi, LCSW-R
Director of Clinical Services



Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	**DOB:**
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Mental Health Association – Columbia & Greene Counties
Mobile Crisis Assessment Team
713 Union Street
Hudson, NY 12534
Telephone: (518) 943-5555 Fax: (518) 947-6400

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☒Admission/Assessment ☒Progress Notes ☒Service Plan ☒Diagnosis ☒Lab Results ☒History and Physical
☒Psychiatric Evaluations ☒Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information
☒Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*_________________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ____ **Date:___/___/___**

Signature of Person Acting for Client: ________________________________ **Date:___/___/___**

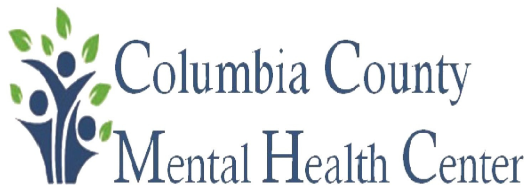
REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME):	**Relationship:**
Signature of Person Revoking Authorization:	Date: / /

Provide the individual served with a copy Place the original in the service record

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com



Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	**DOB:**
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Primary Care Physician: ____________________

____

____

Telephone: ______________________ **Fax:** ______________________

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☐Admission/Assessment ☒Progress Notes ☐Service Plan ☒Diagnosis ☒Lab Results ☒History and Physical
☐Psychiatric Evaluations ☒Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information
☒Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*______________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ______________________ **Date:** ___/___/___

Signature of Person Acting for Client: ______________________ **Date:** ___/___/___

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

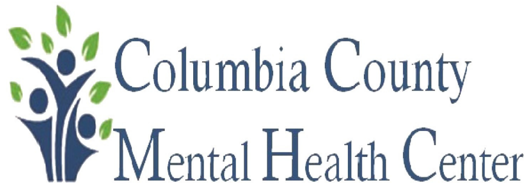
Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /

Provide the individual served with a copy Place the original in the service record

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com



NAME OF CLIENT:	DOB:
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Pharmacy: ____

____

____

Telephone: ______________________ **Fax:** ______________________

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☐Admission/Assessment ☐Progress Notes ☐Service Plan ☐Diagnosis ☒Lab Results ☐History and Physical
☐Psychiatric Evaluations ☐Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information
☐Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*________________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ____ **Date:** ___/___/____

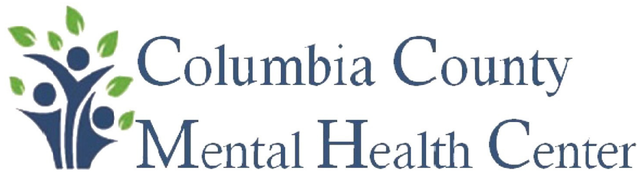
Signature of Person Acting for Client: ______________________________ **Date:** ___/___/____

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME):	**Relationship:**
Signature of Person Revoking Authorization:	Date: / /

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com



Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	DOB:
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

School: ____

____

____

Telephone: ______________________ **Fax:** ______________________

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☐Admission/Assessment ☐Progress Notes ☐Service Plan ☐Diagnosis ☐Lab Results ☐History and Physical
☐Psychiatric Evaluations ☐Psychological Testing/Reports ☐Discharge Summary ☐Medication Information ☐Medical Information
☐Dates and Types of Services Received ☒School Records/IEP/Report Card/Attendance/Disciplinary Records

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*________________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ____ **Date:** ___/___/____

Signature of Person Acting for Client: ________________________________ **Date:** ___/___/____

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /

Provide the individual served with a copy Place the original in the service record

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com

Columbia County Mental Health Center

Authorization to Use or Disclose Protected Health Information

NAME OF CLIENT:	**DOB:**
NAME OF PERSON ACTING FOR CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

____

____

____

Telephone: ______________________ **Fax:** ______________________

2. to the **RECIPIENT:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged:** (check all that apply) ☐Transportation/Accessibility Needs
☐Financial/Billing ☐Admission/Assessment ☒Progress Notes ☐Service Plan ☒Diagnosis ☒Lab Results ☒History and Physical
☐Psychiatric Evaluations ☒Psychological Testing/Reports ☐Discharge Summary ☒Medication Information ☒Medical Information
☒Dates and Types of Services Received ☒**HIV+, AIDS** information ☒**HBV, HCV** information

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*________________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Client: ____ **Date:** ___/___/____

Signature of Person Acting for Client: ______________________________________ **Date:** ___/___/____

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME): **Relationship:**

Signature of Person Revoking Authorization: Date: / /

Provide the individual served with a copy Place the original in the service record

Hixny Electronic Data Access Consent Form

In this consent form, you can choose whether to allow **Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC),** 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 **CCDHS/MHC** 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, the staff of **CCDHS/MHC** 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, the staff of **CCDHS/MHC** 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.

O **I GIVE CONSENT for CCDHS/MHC to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

O **I DENY CONSENT for CCDHS/MHC 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.***

____

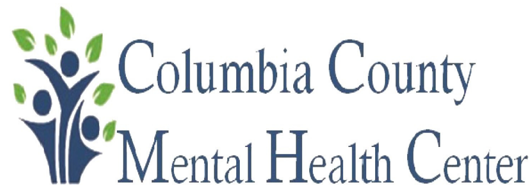
Print Name of Client | **Date of Birth**

____

Signature of Client or Client's Legal Representative | **Date**

____

Print Name of Legal Representative ***(if applicable)*** | **Relationship of Legal Representative to Client**



Details about client information in Hixny and the consent process:

How your information will be used: Your electronic health information will be used by **CCDHS/MHC** only to:

•Provide you with medical treatment and related services;
•Check whether you have health insurance and what it covers; and,
•Evaluate and improve the quality of medical care provided to all clients.

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, 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

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 **CCDHS/MHC**. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

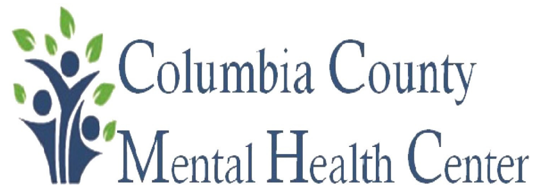
Who may access information about you, if you give consent: Only these people may access information about you: doctors and other health care providers who serve as the medical staff of **CCDHS/MHC** who are involved in your medical care; health care providers who are covering or on call for **CCDHS/MHC** 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 **CCDHS/MHC** at: (518) 828-9446; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (877) 690-2211.

Re-disclosure of information: Any electronic health information about you may be re-disclosed by **CCDHS/MHC** 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 **CCDHS/MHC**. 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, 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 consent form: You are entitled to get a copy of this consent form after you sign it**.**