COMMUNITY CARE PHYSICIANS

Schodack Internal Medicine and Pediatrics New Patient Packet

Name:_____ Date of Birth:_____

Sex:_____ Home Phone:_____ Cell Phone:_____

Pronouns:_____

**Race**: Native American or Alaska Native  Asian or Pacific islander  Back  White  Declined  Unknown

**Ethnicity**: Hispanic  Non-Hispanic Declined  Unknown  **Preferred Language**:_____

**Emergency Contact**:

Name:_____ Relationship:_____

Preferred Phone Number:_____ Secondary Phone:_____

**Pharmacy**:

Local Pharmacy:_____ City/State:_____

Mail order pharmacy:_____

**Past Medical History**:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | Yes | No | Migraines | Yes | No | Acid reflux | Yes | No |
| Heart Attack | Yes | No | Thyroid Problems | Yes | No | Urine Incontinence | Yes | No |
| Heart disease | Yes | No | Osteoporosis | Yes | No | Depression | Yes | No |
| High Cholesterol | Yes | No | Asthma | Yes | No | Anxiety | Yes | No |
| Diabetes | Yes | No | Seasonal Allergies | Yes | No | Cancer (Specify below) | Yes | No |
| Stroke | Yes | No | COPD/Emphysema | Yes | No | | | |

Other Medical Problems:_____

**Review of Systems**: Do you currently have concerns with any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Vision Problems | Yes | No | Leg Swelling | Yes | No | Muscle/Joint Pains | Yes | No |
| Hearing Problems | Yes | No | Leg pain with walking | Yes | No | Memory Problems | Yes | No |
| Headaches | Yes | No | Abdominal Pain | Yes | No | Depression | Yes | No |
| Dizziness | Yes | No | Heartburn | Yes | No | Anxiety | Yes | No |
| Chest Pain | Yes | No | Difficulty Swallowing | Yes | No | Urine Incontinence | Yes | No |
| Palpitations/ Irregular pulse | Yes | No | Constipation | Yes | No | Frequent Urination | Yes | No |
| Shortness of Breath | Yes | No | Recurrent Diarrhea | Yes | No | Blood in Urine | Yes | No |
| Persistent Cough | Yes | No | Blood in stool | Yes | No | Snoring | Yes | No |
| Weight Loss/ Weight Gain | Yes | No | Night Sweats/ Fever | Yes | No | Loss of Sex Drive | Yes | No |

Do you feel safe at home? Yes  No

Would you like sexual transmitted infection testing such as HIV testing?  Yes  No

**Name**:_____ **DOB**:_____

| **Please list any surgeries you have had** | Year |
|---|---|
| ☐ Check if None | |
| | |
| | |
| | |
| | |
| | |
| | |

**Family History:** Do you have any family members with the following (mainly parents, grandparents and siblings)
Adopted, family history unknown_____

| | | | | Who | What age |
|---|---|---|---|---|---|
| Heart attack/Heart Disease | Yes | No | Unsure | | |
| High Blood Pressure | Yes | No | Unsure | | |
| High Cholesterol | Yes | No | Unsure | | |
| Aortic Aneurysm | Yes | No | Unsure | | |
| Brain Aneurysm | Yes | No | Unsure | | |
| Polycystic Kidneys | Yes | No | Unsure | | |
| Stroke | Yes | No | Unsure | | |
| Diabetes | Yes | No | Unsure | | |
| Thyroid Problems | Yes | No | Unsure | | |
| Osteoporosis/ Hip Fracture | Yes | No | Unsure | | |
| Depression | Yes | No | Unsure | | |
| Anxiety | Yes | No | Unsure | | |
| Glaucoma | Yes | No | Unsure | | |
| Hemochromatosis | Yes | No | Unsure | | |
| Colon Cancer | Yes | No | Unsure | | |
| Colon Polyps | Yes | No | Unsure | | |
| Melanoma Skin Cancer | Yes | No | Unsure | | |
| Lung Cancer | Yes | No | Unsure | | |

Other Relevant Family History/Other Cancers: _____

Have any family members died? If so, list age and reason

| | | | |
|---|---|---|---|
| Mother | _____ | Maternal Grandmother | _____ |
| Father | _____ | Maternal Grandfather | _____ |
| Sister (s) | _____ | Paternal Grandmother | _____ |
| Brother(s) | _____ | Paternal Grandfather | _____ |

**Social History**

Are you working? Yes No Retired Occupation: _____

Do you have any children? Yes No Yes and are adult age How many? _____

Please Check: _____ Currently Every Day Smoker _____ I smoke_____ pack(s) per day for _____ years

_____ Current some day smoker_____

_____ Former Smoker _____ Quit Date _____ _____ pack(s) per day for _____years

_____ Never a Smoker

**Name**:_____ **DOB**:_____

| | | Yes / No |
|---|---|---|
| | In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food? | Y N |
| | In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home? | Y N |
| | Are you worried that in the next 2 months, you **may not have stable housing?** | Y N |
| | Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)* | Y N |
| | In the last 12 months, have you needed to see a doctor, **but could not because of cost?** | Y N |
| | In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?** | Y N |
| | Do you ever need help **reading hospital materials?** | Y N |
| | Do you often feel that **you lack companionship?** | Y N |
| | **Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight | Y N |
| | If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs? | Y N |

Patient signature: _____

Provider signature:_____

Date: _____

**Name**:_____ **DOB**:_____

| bothered by any of the following problems? *(use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | | add columns | + | + |
| | | TOTAL: | | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

Alcohol: One Drink =  12oz of Beer  5oz Wine  1.5 oz liquor (one shot)

| | None | 1 or more |
|---|---|---|
| **Males:** How many times in the past year have you had 5 or more drinks in a day? | | |
| **Females**: How many times in the past year have you had 4 or more drinks in a day? | | |

Patient signature: _____

Provider signature:_____

Date: _____

**Name**:_____ **DOB**:_____

| *Allergies:* | |
|---|---|
| Name of Substance (Drug or Food) | Type of Reaction |
| ☐ Check if None | |
| | |
| | |
| | |
| | |

| *Current Medication:* | | | | |
|---|---|---|---|---|
| Prescription Drug (Such as Lipitor, Eye Drops, Creams) | Strength (Such as 50mg) | Directions (Such as 2 Tablets in the AM) *Check box if taken only as needed* | | Prescribed by (Such as John, Doe, MD) |
| ☐ Check if None | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |
| | | | ☐ | |

| Over-the-Counter Medication (Such as Aspirin) | Strength | Directions (Such as for headaches, when needed) |
|---|---|---|
| ☐ Check if None | | |
| | | |
| | | |
| | | |
| | | |

- I understand that my eligibility for coverage by my insurance company may be confirmed at this time. I wish to receive medical services from Community Care Physicians, P.C. If is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.
- I understand that my Primary Care Provider (PCP) could not be verified by my insurance carrier at this time. My PCP is states on this form. I wish to receive medical service from Community Care Physicians, P.C. If it is determined that I am not listed with the named provider as provider. I agree to verify this information with the member services department (Contact the number on the back of my insurance card) of my insurance carrier.
- I hereby authorize any insurance benefits to be paid directly to the provider furnishing services and recognize my responsible to pay for any non-covered services. This includes denials as a result of not having an updated CCP MD listed with my insurance company as my primary care physician.

Signature of Patient/ Legal Guardian: _____

Date: _____

**Name**:_____ **DOB**:_____

Do you have a caregiver? Yes No If yes: Name: _____ Phone: _____
If Yes and you would like use to be able to speak with them about your care, please complete and sign a HIPAA form.
Advance Directives: If you have a Health Care Proxy and/or Advance Directives, please give a copy to office
Are you interested in receiving information on Advance Care Planning Yes No

Please list any Specialist that you see:

| | Name of Doctor/Address/Phone | Last Visit |
|---|---|---|
| Allergist | | |
| Cardiology | | |
| Endocrinology | | |
| ENT (Ear/Nose/Throat) | | |
| Gastroenterology | | |
| Gynecology | | |
| Nephrology (Kidney) | | |
| Oncology/Hematology | | |
| Ophthalmology (Eye Doctor) | | |
| Orthopedics | | |
| Pain Management | | |
| Podiatry (Foot Doctor) | | |
| Psychiatry (Prescribes Meds) | | |
| Psychology (Talk Therapy) | | |
| Rheumatology | | |
| Urology | | |
| Other | | |

**Patient signature:**_____

**Provider Signature:** _____

**Date:**_____

COMMUNITY CARE PHYSICIANS

# GENERAL

# PATIENT HIPAA AUTHORIZATION

THIS IS NOT A MEDICAL RECORDS REQUEST FORM. TO REQUEST A COPY OF YOUR RECORDS, PLEASE SEE THE FRONT DESK OR VISIT www.communitycare.com

| | |
|---|---|
| | |

**Patient's Full Name (Last, First)** **Patient's Date of Birth**

## Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **RELEASED or SHARED BY Community Care Physicians** to the following:

Name(s)/Entities (please include address and phone number):_____

_____

_____

## Step 2: What Can We Share?

**I authorize the release of the following health information:**

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

**Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)**

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

**My Sensitive Information:**

**Please Initial**: _____: I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information below. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

**DO NOT INCLUDE MY:**

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

**Reason for Release:**

☐ At request of patient ☐ Transferring Care out of CCP to a New Provider ☐ Legal Request ☐ Other:_____

## Step 3: When Does this Authorization Expire?

This authorization will expire on_____

**{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.**

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. This authorization may include disclosure of information relating to all Community Care Physicians' offices I have visited. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

***Print Name of Patient or Legal Guardian*** ***Signature of Patient or Legal Guardian***

**Date**: _____ ***Relationship to Patient***: _____

# PATIENT HIPAA AUTHORIZATION

# TO SEND RECORDS TO COMMUNITY CARE

| | |
|---|---|
| | |

**Patient's Full Name (Last, First)** **Patient's Date of Birth**

## Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **SENT TO** the following Community Care Physicians location:

**Schodack Internal Medicine and Pediatrics**
**35 Empire State Boulevard**
**Castleton-On-Hudson, NY 12033**
**P: 518-477-2167 F: 518-477-5182**

## Step 2: Where is Your Information Coming From?

Name/Entity:_____Phone: _____

Address/City, State, Zip:_____Fax:_____

## Step 3: What Can CCP Receive?

**I authorize the release of the following health information:**

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

**Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)**

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

**My Sensitive Information:**

**Please Initial**: _____: I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information below. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

**DO NOT INCLUDE MY:**

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

**Reason for Release:**

☐ At request of patient ☐ Transferring Care to a CCP Provider ☐ Other:_____

## Step 4: When Does this Authorization Expire?

This authorization will expire on_____

**{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.**

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

***Print Name of Patient or Legal Guardian*** ***Signature of Patient or Legal Guardian***

**Date**: _____ ***Relationship to Patient***: _____

# HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
## Community Care Physicians

In this Consent Form, you can choose whether to allow Community Care Physicians to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York, Inc., doing business as Hixny ("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 Community Care Physicians 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, Community Care Physicians' staff 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, Community Care Physicians 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). To learn more about Hixny and ehealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask Community Care Physicians for it, or go to the website www.hixny.org.

**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.

- **I GIVE CONSENT for Community Care Physicians to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

- **I DENY CONSENT for Community Care Physicians 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 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) |

**Details about patient information in Hixny and the consent process:**

**1. How Your Information Will be Used**. Your electronic health information will be used by Community Care Physicians 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.

**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, Community Care Physicians 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

**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 is available from Community Care Physicians . You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

**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 Community Care Physicians' medical staff who are involved in your medical care; health care providers who are covering or on call for Community Care Physicians' doctors; and staff members 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, call Community Care Physicians at: (518) 452-1337; or call Hixny at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

**6. Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Community Care Physicians 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.

**7. Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

**8. Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Community Care Physicians. 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 at www.hixny.org, or by calling (518) 783-0518. **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.**

**9. Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

COMMUNITY CARE PHYSICIANS

# NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

## PLEASE REVIEW THIS NOTICE CAREFULLY.

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE CONTACT:**

**Mackensie Greene, Esq.**
Privacy Officer
6 Wellness Way, Suite 201
Latham, NY 12110 (518) 782-3700

**C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

The following categories describe the different ways in which we may use and disclose your IIHI. The uses are for Treatment, Payment, and Operations (TPO).

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
   **Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.**

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. We will not sell your data to an outside entity, nor will we permit an outside entity from accessing your information for purposes of informing you of health-related benefits or services.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you in some limited circumstances. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

**D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR IIHI**

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein and the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your physician specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

   You also have the right to request a restriction in our use or disclosure of your IIHI to a health plan where the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. In this circumstance, we are required to agree to your request, except where we are required by law to make a disclosure.

   In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to your physician. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non- treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your physician. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Mackensie Greene, Esq. at (518) 782-3700.**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Mackensie Greene, Esq. at (518) 782-3700.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions to include certain treatment, payment, or healthcare operations); use or disclosure of IIHI for marketing purposes; and disclosures that constitute a sale of IIHI.

   Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. **Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured IIHI.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Mackensie Greene, Esq. (518) 782-3700.**

Effective Date of Notice: April 14, 2003
Revised: June 1, 2013

COMMUNITY CARE PHYSICIANS

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Community Care Physicians

# RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians
Print Patient Name

Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Guardian | Date of Birth | Date

_____ _____
Witness | Date