Latham Medical Group

6 Wellness Way, Suite 114 • Latham, NY 12110
Phone: (518) 785-5881 • Fax: (518) 785-1574
www.lmg.communitycare.com
www.communitycare.com/patient-portal/

COMMUNITY CARE PHYSICIANS

Holly Cleney, MD • Kristine Campagna, DO • Tami Seaman, MD • Samantha Ludwig, MD • Mary Kate Barnett, MD
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Raelyn Goslin, PharmD, BCACP • Heather Kleitgen, BSN, RN, CDCES

Lynn Misiti, Practice Manager

Dear Patient,

Welcome to Latham Medical Group. Thank you for choosing us as your healthcare provider. We'd like to be the first place you think of for all your medical needs. Our team is dedicated to the health and wellness of our patients.

To ensure that we can provide you with the highest level of care, we need you to complete the attached packet and return it **no later than 2 weeks prior to your New Patient appointment. If we do not receive your packet back and completed, we will reschedule your appointment.**

You can return the packet to our front desk, email it to LMGnewpatient@communitycare.com or fax it to 518-785-1574. *We do not recommend mailing the packet as we cannot ensure it will arrive back to us at least 2 weeks prior to your appointment.*

Be sure to complete the following sections:

- ☐ Patient Registration Form
- ☐ Medication List
- ☐ Health Exam History Form
- ☐ HIPAA- Notice of Privacy Acknowledgement Form (please sign)
  - This is whom can request records or have access to your medical history in case of emergency.
  - This form has 5 numbered sections and a signature to complete
- ☐ Medical Records Request
  - This is a form so that we can request your past medical records from other offices.
  - This form has the Community Care logo centered at the top of the page.
- ☐ HIXNY Form (please sign and check appropriate box)
  - This form allows us to access your health information via the Healthcare Information Xchange of New York. For example, this helps notify us if you are hospitalized.

If you must reschedule your appointment, you must contact our office at least 24 hours in advance.

Our phone number is 518-785-5881.

If you No-Show your appointment, you will be charged a $50 fee and we will not reschedule your appointment with our office.

We look forward to seeing you here at Latham Medical Group. Thank you for giving us the opportunity to participate in your care!

Sincerely,

Latham Medical Group

6 Wellness Way Suite 114
Latham, NY 12110

Phone: 518-785-5881
Fax: 518-785-1574

Demographics ***Please complete in full***	**MRN**
Last Name	**Home Phone**
First Name	**Work Phone**
Date of Birth	**Cell Phone**
Sex	**Email**
Marital Status	**Primary Care Physician**
Address	
City **State**	**Zip Code**

If patient is under the age of 19:

Mother's first name ____________________ **Mother's maiden name** ______________________________

Gender Identity ***please select one:***	**Sexual Orientation** ***please select one:***	**Preferred Pronouns:**
o Male	o Heterosexual	o Male
o Female	o Gay/Lesbian/Homosexual	o Female
o FTM Transgender	o Bisexual	o Gender Neutral
o MTF Transgender	o Other: ______________	o Other: ______________
o Non-Binary/Genderqueer	o Don't Know	o Choose Not to Disclose
o Other: ______________	o Choose Not to Disclose	
o Choose Not to Disclose		

Primary Insurance	**Secondary Insurance**
Insurance Company	**Insurance Company**
Policy/ID#	**Policy/ID#**
Group #	**Group #**
Subscriber	**Subscriber**
PCP/Specialist Co-Pays ***Amount $***	**PCP/Specialist Co-Pays** ***Amount $***

- ❖ **I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. I wish to receive medical service from Community Care Physicians, P.C. If it 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 Physician (PCP) could not be verified by my insurance carrier at this time. My PCP is stated on the other side of 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 my PCP, I understand that I will be responsible for payment of all services provided to the named 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 responsibility to pay for any non-covered services. This includes denials as a result of not having an updated PCP MD listed with my insurance company as my primary care physician.**

Signature of Patient/ Legal Gaurdian: ____

Date: ________________________

This packet must be returned at minimum two (2) weeks prior to scheduled appointment, please complete fully and return either

In Person: Bring this to our front desk and a staff member would be happy to assist you

Via Fax: 518-785-1574

Email: LMGnewpatient@communitycare.com

LMG does NOT recommend mail as we cannot guarantee we will receive in a timely manner

Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. Thank you!

Patient Name:		Date of Birth:
Emergency Contact	Relationship	Phone
Pharmacy		Address/City
Mail Order Pharmacy		Phone

Race: American Indian or Alaska Native Asian or Pacific Islander Black Hispanic White Declined Unknown	
Ethnicity: Hispanic Non-Hispanic Declined Unknown	**Preferred Language:**

How would you like to receive your healthcare **Reminders:** CELL PHONE HOME PHONE WORKPHONE MAIL DECLINE
Reminders will be in your Patient Portal account if/when you sign up as well

Allergies

Name of Substance (drug or food)	**Type of Reaction**
☐ Check if none	

Current Medications

Prescription Drugs (such as Lipitor, eye drops, creams)	**Strength** (such as 50 mg)	**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 Medications (such as Aspirin)	**Strength**	**Directions** (such as for headaches, when needed)
☐ Check if none		

Herbs, Vitamins, Minerals, Etc. (such as St. John's Wort)	**Strength**	**Directions** (such as one tablet each day)
☐ Check if none		

New Patient History Form

NAME ______________________________ DATE OF BIRTH______________

PAST MEDICAL HISTORY: Do you have any of the following problems?

High Blood Pressure	YES	NO	Migraines	YES	NO	Acid Reflux/Ulcers	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	Emphysema/COPD	YES	NO			

Other Medical Problems: ____

REVIEW OF SYSTEMS: Do you currently have concerns with any of the following? If any of the below symptoms are severe or are worsening, contact your Primary Care Physician prior to this scheduled appointment date.

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
Palpitation/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
Unintentional weight loss/			Night sweats/fever	YES	NO	Loss of sex drive	YES	NO
weight gain	YES	NO	Skin problems	YES	NO			

SOCIAL HISTORY:

Are you working? YES NO RETIRED Occupation ________________________________

Are you currently: MARRIED SINGLE SINGLE BUT IN A RELATIONSHIP DIVORCED WIDOWED SEPARATED

Are you currently sexually active? YES NO
Would you like to be screened for Sexually Transmitted Diseases? YES NO

Do you have any children? YES NO YES AND ARE ADULT AGE How many? _________

Please check: Are you a CURRENT 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 ______

Do you have or have you had exposure to secondhand smoke? YES NO If yes, from _________ for how long? ______

How often do you drink alcohol? Never Rarely Occasionally 1-2/Day 3-4/Day >5/Day

Is there any family history of alcohol problems? YES NO If yes, which family member(s)? ________________

Do you have any history of recreational drug use? Current use YES NO What drug(s)? ____________________________
Past use YES NO What drug(s)? ____________________________

Exercise: I exercise __________times per week. Type of exercise ____
OR I rarely exercise.

Diet: *I try to eat healthy* or *My diet needs improvement* (please circle)
Describe diet (how much fast food, avoid meat, fat, salt or sugar etc) ____
I get calcium from the following sources on a daily basis ____

NAME____ DATE OF BIRTH___________________________

SURGICAL HISTORY: Please list any surgeries that you have had and what year done: None___________

1.________________________________ 2.______________________________ 3.________________________

4.________________________________ 5.______________________________ 6.________________________

Have you had a **colonoscopy**? YES NO If YES, when and with whom? _______________________________

FAMILY HISTORY: Do you have any family members with the following (mainly parents, grandparents and siblings)

Adopted, family history not known _______

				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 problem	YES	NO	UNSURE	___________________	_______
Osteoporosis	YES	NO	UNSURE	___________________	_______
Hip fracture	YES	NO	UNSURE	___________________	_______
Spinal fracture	YES	NO	UNSURE	___________________	_______
Depression	YES	NO	UNSURE	___________________	_______
Anxiety	YES	NO	UNSURE	___________________	_______
Glaucoma	YES	NO	UNSURE	___________________	_______
Hemochromatosis	YES	NO	UNSURE	___________________	_______
Breast cancer	YES	NO	UNSURE	___________________	_______
Ovarian cancer	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 if known:

MOTHER ___________________________________ MATERNAL GRANDMOTHER _________________________________

FATHER ___________________________________ MATERNAL GRANDFATHER _________________________________

SISTER(S) ___________________________________ PATERNAL GRANDMOTHER _________________________________

BROTHER(S)___________________________________ PATERNAL GRANDFATHER _________________________________

ADVANCE DIRECTIVES: If you have a Health Care Proxy and/or Advance Directives, please bring copies of these to your appointment.
Are you interested in receiving information on Advance Care Planning? YES or NO

PLEASE CONTINUE TO THE NEXT PAGE

NAME ______________________________________ DATE OF BIRTH __________________

GYNECOLOGY:
(*If this does not apply to you, please move onto next section*)

If you see a gynecologist, who do you see?_______________________ When did you last see them?_____________

Have you gone through menopause? YES NO If yes, have you had any bleeding or spotting since? YES NO

If not menopausal:
Are your periods monthly and regular? YES NO
If no, how often do they occur? ____________________________

Do you experience any heavy bleeding? YES NO Heavy cramping? YES NO

Do you have any of the following problems?

Endometriosis	YES	NO	Hot flashes	YES	NO
Polycystic ovarian syndrome	YES	NO	Vaginal dryness	YES	NO
Recurrent yeast infections	YES	NO	Painful Intercourse	YES	NO
Fibrocystic breasts	YES	NO			

When was your last **PAP** smear? ___________ Have you ever had an abnormal PAP smear? YES NO

Have you ever had a **Mammogram**? YES NO If yes, when was your last one? ___________________________

Have you ever had a **DEXA** (bone density scan)? YES NO If yes, when was your last one? ________________

Do you ever do self breast exams? YES NO

Do you have any current problems or concerns with your breasts? YES NO

If yes, what form of birth control method(s) do you use?

___ None	___ Had tubal ligation	___ Birth control pill	___ Partner had vasectomy
___ Condoms	___ IUD	___ Nuvaring	___ Diaphragm
___ Patch	___ Withdrawal or rhythm method		

Do you have any current or past problems with anorexia/bulimia/eating disorder?	YES	NO	UNSURE
Do you frequently skip meals or avoid eating to lose weight?	YES	NO	
Do you exercise for hours at a time to lose weight?	YES	NO	
Do you use any diet pills, supplements or laxatives to lose weight?	YES	NO	
Have you ever made yourself vomit to lose weight?	YES	NO	

Do you have any current or past issues with domestic violence? YES NO UNSURE
If current or unsure, this can be discussed today or a later time if preferred and will be done with total confidentiality.

NAME:____ DATE OF BIRTH______________________

Do you have a caregiver? (Circle one) **YES** or **NO** If Yes:

Name:____

Phone:____

Relationship:____

Remember to add this person to your HIPAA form

PLEASE LIST ANY SPECIALISTS THAT YOU HAVE SEEN IN THE LAST 2 YEARS

Specialty	Name of Doctor and Practice	Year of Last Visit
PODIATRY (*Foot Doctor*)		
OPHTHALMOLOGY (*Eye Doctor*)		
CARDIOLOGY		
ORTHOPEDICS		
GASTROENTEROLOGY		
RENAL/KIDNEY *(Nephrology)*		
UROLOGY		
PSYCHIATRY *(Prescribes Meds)*		
PSYCHOLOGY *(Talk Therapy)*		
RHEUMATOLOGY		
NEUROLOGY		
DERMATOLOGY		
ENDOCRINOLOGY		
ALLERGIST		
ENT *(Ear/Nose/Throat)*		
GYNECOLOGY		
PAIN MANAGEMENT		
HEMATOLOGY/ONCOLOGY		
PULMONOLOGY		
OTHER		

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

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***: ___________________________

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.

- o **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.

- o **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**.**

HIXNY
HEALTHCARE INFORMATION XCHANGE
NEW YORK

Your Health Information . . . Always at Your Doctor's Fingertips

To give you the safest, best care, your doctor usually needs a lot of information: your medical history, allergies, prescriptions, specialist visits, lab tests and more. The Healthcare Information Xchange of New York (HIXNY pronounced HIX-KNEE) is an easy way for your doctors to get this information.

HIXNY has created a secure, electronic service for exchanging health information among hospitals and doctors in the Capital Region. This service allows your doctor to view and share information like medication history, allergies, and test results. It also lets doctors write prescriptions online and send them to your pharmacy.

The benefits of having accurate, up-to-date information include fewer repeated tests, reduced risk of mistakes, easier second opinions, and less chance of drug interactions.

Why does my doctor need online access to my medical information?
At a routine office visit, your doctor needs to have your current records. In a medical emergency, the doctors treating you may not have time to track down critical information that could affect your treatment – and you may not be able to provide it. If you sign up with HIXNY to make your information available online to the doctors who need it, HIXNY can literally save lives.

How do doctors get my information now?
Your doctors rely on phone calls, faxes, mail, and you to provide information they need. When you sign up for HIXNY, your doctor will get a lot of your information from others who treat you using a secure online service. By spending less time tracking down information, doctors can spend more time on patient care.

Will my medical information be safe?
By law, HIXNY uses the most advanced security to protect your privacy. Access to your information will be limited to doctors treating you, and HIXNY tracks every person who accesses information. This service just makes it more efficient to get the information that is already being shared via telephone, faxes, and mail. There is no database that stores your information, just a secure way to share information between your doctors.

How do I sign up?
All you need to do is sign the ***HIXNY Consent Form*** and return it to the registration desk.

What if I don't want some of my medical information shared through HIXNY?
HIXNY is not set up to exclude specific information, such as mental health information or sexually transmitted diseases. However, your information is kept private and secure. Only medical professionals who help provide your care can see your information.

What should I do if I change my mind?
If you change your mind, ask for another ***HIXNY Consent Form*** to change your decision.

Why can't my teenager participate in HIXNY?
New York State law allows teenagers to seek care for some conditions without parental knowledge or consent. Having their information accessible through HIXNY could compromise the confidentiality protection guaranteed to teenagers by those laws.

What area does HIXNY cover?
HIXNY includes 17 upstate counties: Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, St. Lawrence Saratoga, Schenectady, Schoharie, Warren, and Washington.

Get More Information: Ask us or contact HIXNY: (518) 783-0518 or visit www.hixny.org.

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:

Latham Medical Group
6 Wellness Way
Suite 114
Latham, NY 12110
P: 518-785-5881 F: 518-785-1574

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***: ____________________