The Chautauqua Center

Our Family Caring For Your Family

107 Institute Street, Jamestown NY 14701 Phone: 716-484-4334
319 Central Avenue, Dunkirk NY 14048 Phone: 716-363-6050
Dunkirk Pediatric Office: 1134 Central Avenue, Dunkirk NY 14048 Phone: 716-363-6036
Hours: Monday-Thursday 8am-7pm and Friday 8am-5pm
www.tcchealth.org

Designated As A Patient Centered Medical Home

Our designated Patient Centered Medical Home is a team approach to providing total health care. Your medical home team will include your health care provider and others who support you. The medical home is intended to result in more personalized, coordinated, effective, and efficient care. You are the most important person on the health team.

General Information for New Patients:

1. **Access to Care, Communication and Information:**

- You can communicate with a Medical Home Team member anytime during office hours by calling 716-363-6050.
- You can avoid going to the emergency room by communicating your urgent health needs to one of the Medical Home Team members. He/she will assist you in seeking the appropriate care.
- We will provide you with information about your health and assist you in managing your own healthcare needs.
- Contact your Medical Home Team directly to arrange an appointment or to discuss your healthcare needs by calling our office.
- For urgent healthcare needs after office hours, please call our office at 716-363-6050. The answering service will answer your call and the physician on call will return your call promptly. For *serious* medical emergencies, please call 911.
- For urgent care issues during office hours, your primary care physician (or another one of our team members) will see you on the very day that you have an urgent care need. Simply call our office to schedule an appointment or use our convenient walk-in service.
- Many urgent healthcare needs can be handled by your medical home team. Working with your Medical Home Team will help you avoid a prolonged and expensive trip to the emergency room.
- In order for us to maintain coordination of your care, please notify the Medical Home Team if you are seen by another provider, hospital or emergency room.

2. **Patient Portal:**

- Sign up for our online Patient Portal to access medical records, message your provider, view lab results, etc.
- Go to https://22211-1.portal.athenahealth.com/ or visit www.tcchealth.org and click the Patient Portal tab.

3. **Patient responsibility:**

- Provide us with a complete medical history and the names of your other health care providers.
- Take an active part in your health and work closely with us. Do your best to follow your plan of care.
- Tell us if you are having trouble sticking to your plan of care.
- Let us know if your plan is not working for you.
- Share your needs and concerns.
- Tell us all your medications that you are taking. Let us know of any problems.
- Learn about caring for yourself and your medical conditions. Make healthy lifestyle choices.
- Let us know whenever you see other health providers and specialists, go to an emergency department, or are hospitalized, and what medications they put you on or changed.
- Ask all doctors you see to send us a report about your care and test results.
- Keep your appointment as scheduled or call and let us know when you cannot attend.

4. **Our Commitment to you and your Family:**

- We will help you get to know our practice.
- We will provide continuity from birth to the elder and coordinate your care with specialists. We take responsibility for arranging care with other health professionals.
- We will provide you with same-day appointments whenever possible.
- We will listen to your questions and concerns and will explain your treatment and test results in an easy-to-understand way.
- We will provide education, counseling, and self-management options to support you and will find evidenced based care that reflects quality and safety.
- We will be mindful of the financial cost of care we provide and offer equal access to care to all patients regardless of payment source. Our staff can help any uninsured patients with information about obtaining health insurance coverage.
- We will include you in decisions about your health care and help you decide what care is best for you.
- We will care for you and your family with respect, kindness, and sensitivity to your religious and cultural beliefs.
- We will support and encourage our patients with self-management.
- We will share our quality improvement efforts with the community via website, bulletin board and other methods.

Getting ready for your appointment

- Make a list of health questions.
- Make a list of past and present health care providers. Write down their name, address, and phone number. We will have you sign a release so we can access your medical records from previous providers.
- Bring all medications in their original containers.
- Bring your insurance card and co-pay or you can apply for financial assistance if uninsured. We have a sliding fee discount program. Bring recent pay stubs to apply.
- Bring Photo ID.
- Parent or guardian needs to accompany a patient under 18 years of age.
- If you choose, ask a family member or trusted friend to attend the appointment with you.

During your appointment:

- Ask questions.
- Discuss what health issues to work on first.
- Understand what needs to be done before leaving our office.
- Ask how your care providers can be reached after hours.
- Repeat back to the care provider the most important things discussed during the visit.

Our Patient Centered Medical Home provides comprehensive care for every member of the family

- Preventive Care to Keep You Well
- Chronic Disease Management
- Work and School Physicals
- Same Day Sick Care
- Dental Care
- Mental Health Counseling/Substance Abuse Services
- Family Planning (Birth control methods, STI testing, education)
- Medicare, Medicaid, Child Health Plus, Family Health Plus and all major insurances plans are accepted and we have staff who can assist with the listed plans if you are uninsured
- Care Coordination and Bilingual Representatives
- This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals

The Chautauqua Center

Our Family Caring For Your Family

PATIENT INFORMATION

NAME (Last, First, Middle Initial) _____BIRTHDATE _____ SSN# _____-_____-_____
GENDER IDENTITY: Female ____ Male____ Transgender Male____ Transgender Female ___ Choose not to disclose____
ADDRESS _____CITY _____ STATE _____ ZIP _____
MARITAL STATUS: [ ]Single [ ]Married [ ]Separated [ ]Divorced [ ]Widowed
ARE YOU A STUDENT? [ ]Yes [ ]No EMAIL _____ [ ]NO EMAIL

HOME PHONE: _____CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT

NAME _____TEL # _____ BIRTHDATE_____

ADDRESS _____CITY _____ STATE _____ ZIP _____

PRIMARY EMPLOYER	OCCUPATION
EMPLOYER NAME _____ ADDRESS _____ CITY _____STATE _____ ZIP _____ WORK # _____ FULL TIME ____ PART TIME ____	Agriculture ( ) Hospitality ( ) None Business ( ) Human Services Custodial/Maintenance Computer ( ) Manufacturing Construction ( ) Religion Government ( ) Transportation Healthcare ( ) Other

PRIMARY INSURANCE (Please present insurance card(s) at time of visit)

INSURANCE NAME _____ POLICY # _____ GROUP # _____

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

SSN# _____-_____-_____ BIRTHDATE _____ GENDER _____

INSURANCE PHONE _____ EFFECTIVE DATE _____ EMPLOYER _____

SECONDARY INSURANCE (if applicable)

INSURANCE NAME _____ POLICY # _____ GROUP # _____

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

SSN# _____-_____-_____ BIRTHDATE _____ GENDER _____

INSURANCE PHONE _____ EFFECTIVE DATE _____ EMPLOYER _____

PATIENT NAME: _____ DOB: _____

ADITIONAL PATIENT INFORMATION

RACE (Defined by the US Office of Management and Budget and the US Census Bureau)

[ ]African American or Black [ ]Native American or Alaska Native [ ]Asian [ ]Caucasian/White

[ ]Multiracial (two or more races) [ ]Native Hawaiian/Other Pacific Islander

ETHNICITY (Defined by US Office of Management/Budget/US Census Bureau): [ ] Non-Hispanic [ ]Hispanic/Latino(a)

SEXUAL ORIENTATION: Straight___ Bisexual___ Lesbian/Gay____ Choose not to disclose____ Other____

PREFERED LANGUAGE: _____ English _____ Spanish _____Other(Please list:_____)

ARE YOU A VETERAN [ ]YES [ ]NO

ARE YOU A MIGRANT/SEASONAL WORKER [ ]YES [ ]NO

HOW DID YOU HEAR ABOUT US (Please check box and list more detail if possible)

[ ]Website _____ [ ]Family/Friends _____ [ ]Community Org/Provider _____

[ ]Employer _____ [ ]School _____ [ ]Radio _____ [ ]Event _____

[ ]Newspaper _____

HOUSING Living Arrangement:[ ]Rent/Mortgage [ ]Homeless [ ]Transitional [ ]Homeless Shelter [ ]Public Housing(Sect.

HOUSEHOLD SIZE (# of immediate family members):_____

HOUSEHOLD ANNUAL INCOME _____

Choose not to disclose household income (check box) [ ]

CAREGIVER INFORMATION

Please list your primary caregiver below, which is the person who provides your daily care. (Example -Self, Parent, Spouse Sibling, Child). If you are your primary care giver please check this box: ☐

NAME (Last, First, Middle) _____SSN: ____-____-____ BIRTHDATE _____

LOCAL ADDRESS _____ CITY/STATE/ZIP _____

WORKER'S COMPENSATION / NO-FAULT INJURY

Is today's visit related to a Worker's Compensation injury? [ ] NO [ ] YES - Please request and complete our intake form.

If so, please provide verification of your employer's consent for you to receive treatment.

I request that payment of Medicare/Insurance benefits be made to me or on my behalf to **The Chautauqua Center** for any services furnished to me by that provider. I authorize any holder of any information about to release to the Health Care Financing Administration, its agents, or other insurances any information needed to determine these benefits payable for related services.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE Revised 11/2020

The Chautauqua Center

Our Family Caring For Your Family

General Consent for Care and Treatment

TO THE PATIENT:

This consent provides us with your permission to perform reasonable and necessary MEDICAL, DENTAL AND BEHAVIORAL HEALTH examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite offices under common ownership of The Chautauqua Center, including visits that are conducted through telehealth (audio and video) means. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue at any time services being provided.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, mid-level provider (Nurse Practitioner, Physician Assistant or Registered Nurse, Licensed Social Worker/Counselor, Dentist or Dental Hygienist, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary examination, testing and treatment for the condition which has brought me to seek care at this practice, including immunizations reported to NYSIIS.

I certify that the insurance information which I have provided is complete and correct. I accept the responsibility of advising and providing TCC, prior to service, of no fault or workers' compensation information for treatment of eligible inquires or illnesses. I authorize TCC to release medical, behavioral health and/or dental information necessary to process insurance claims and release information back to my physician. By my signature below, I hereby consent to treatment, assignment of financial benefits directly to The Chautauqua Center and any associated healthcare and/or dental entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consents.

_____ _____

Print Patient's Name **Date of Birth**

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____ _____

Print Name of Parent/Guardian **Relationship to Patient**

_____ _____

Signature of Witness **Date**

Form Created: December 04, 2017

The Chautauqua Center

Our Family Caring For Your Family

A Community Primary Care Practice

PERMISSION TO CONTACT FORM ABOUT INSURANCE OR DISCOUNT

DO YOU WANT TO KNOW MORE ABOUT OUR SLIDING FEE DISCOUNT PROGRAMS FOR INDIVIDUALS WHO DO NOT HAVE/WANT INSURANCE OR HAVE A HIGH DEDUCTIBLE?

Would you like more information:_____Yes or _____No (please check one)

WOULD YOU LIKE TO APPLY FOR INSURANCE?_____Yes or _____No (check one)

FAMILY HOUSEHOLD SIZE: _____

ANNUAL HOUSEHOLD INCOME: $_____

I already have insurance: _____ (Please check and sign below)

Name (please print) :_____

Home Phone: _____ Cell Phone: _____Email address:_____

When is the best time to contact you: _____ Mornings _____Afternoons_____ Evenings_____

Signature:_____ Date:_____

- By completing and signing this form, I give permission for The Chautauqua Center to have a Certified Application Counselor/Facilitated Enroller to contact me regarding health insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME (LAST, FIRST, M.I.)

_____

SEX_____DATE OF BIRTH_____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth in this form. I understand that:

1. This authorization may include disclosure of information relating to Alcohol and Drug Treatment, Mental Health Treatment, and Confidential HIV/AIDS-Related Information only if I place my initials on the appropriate line. In the event the health information described below includes any of these types of information, and I initial the line corresponding to that information, I specifically authorize release of such information to the person(s) indicated below.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law, specifically referring to Title 42 of the Code of Federal Regulations governing the confidentiality of these types of records.
3. I have the right to revoke this authorization at any time by writing to The Chautauqua Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that my refusal to sign will not affect my abilities to obtain treatment from The Chautauqua Center.
5. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR Pts. 160, 164 and NYS Mental Hygiene Law 33.16).

To/From:	To/From:
The Chautauqua Center 319 Central Ave, Dunkirk, NY 14048 Ph: (716)363-6050/Fax: (716)363-6333 107 Institute St, Jamestown, NY 14701 Ph: (716)484-4334/Fax: (716)484-4140	

Purpose for release of Information: Continuation of care at The Chautauqua Center.

Unless previously revoked by me, the specific information below may be disclosed from: _____(date) until I no longer am receiving services from The Chautauqua Center, if I have initialed under the specific area.

Medical	**Dental**	**Mental Health**	**Substance Abuse**	**HIV/AIDS**
_____	_____	_____	_____	_____

If not the patient, name of person signing form (printed):	Authority to sign on behalf of patient:
Patient Signature: I certify that I authorize the use of my health information as set forth above.	Date:
Witnessed By:	Date:

N**otice of Privacy Practices**

Effective April 14, 2003, in compliance with the new Federal and State Health Insurance Portability and Accountability ACT (HIPAA) regulations, this notice describes how medical information may be used and disclosed and how you can get access to this information. Please read it carefully.

Purpose: To advise you of your privacy rights as a patient of The Chautauqua Center, Inc. (TCC) and to advise you on how TCC may use and disclose your health information.
Commitment: Recognizing that the health information is personal, we commit to keeping this information private to the extent allowed by law and described in this notice. All TCC employees, volunteers and interns must follow the terms of this notice.
Protected Health Information: Is any information that TCC creates or receives about you and your past, present or future physical or mental health, healthcare services or payment for health care provided. Examples of PHI include demographic information, prescriptions, information related to assessment, diagnosis and treatment, insurance and billing information.

Use and Disclosure of PHI: Federal law allows that PHI may be used and disclosed without written authorization for the following purposes:

- Treatment – TCC will use disclose PHI to provide, coordinate, and manage treatment and services. This may include coordination or management of your care with a third party.
- Payment – Your PHI will be used as necessary to attain payments for services rendered
- Health Care Operations – Your PHI may be used to respond support the activities relative to your healthcare. This could include accreditation, quality of care, staff training, managing and planning. Some of the functions may be accomplished via contract with outside vendors known as business associates.
- Abuse Reporting – Your PHI may be used or disclosed to report suspected abuse, neglect or domestic violence as mandated, to Federal, State or Local authorities.
- Legal Purposes – Your PHI may be used to respond as required by law to i.e., court orders, subpoenas, law enforcement purposes.
- Public Health – Your PHI may be used or disclosed to public health or regulatory authorities including preventing diseases, injury or disability, reporting adverse events.
- Health Oversight – Your PHI may be disclosed to governmental oversight agencies to comply with legal mandates such as inspections and investigations.
- Corner or Funeral Services – Your PHI may be disclosed to corner or funeral director as authorized by law including to determine the cause of death or identification.
- Workmen's compensation – Your PHI may be disclosed for your worker's compensation benefit determination.

Patients' Bill of Rights

As a patient in New York State, you have the right, consistent with law, to:

a. received service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
b. be treated with consideration, respect, and dignity including privacy in treatment;
c. be informed of the services available at the center;
d. be informed of the provisions for off-hour emergency care;
e. be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
f. receive and itemized copy of his/her account statement, upon request;
g. obtain from his/her health care practitioner, or the heath care practitioners delegate, complete and current information concerning his/her diagnosis, treatment, and prognosis in terms the patient care be reasonably expected to understand;
h. receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
i. refuse treatment to the extent permitted by law and to be fully informed of the medial consequences of his/her actions;
j. refuse to participate in experimental research;
k. voice grievances and recommend changes in policies and services to the center's staff, the operator, and the New York State Department of Health without fear of reprisal;
l. express complaints about the car and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The enter is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Health Systems Management;
m. privacy and confidentiality of all information pertaining to the patient's treatment;
n. approve or refuse the release or disclosure of the contents of his/her medical record to any healthcare practitioner and/or health-care facility except as required by law or third-party payment contract;
o. access his/her medical record pursuant to the provisions of section 188 of the Public Health Law, and Subpart 50-3 of this title;
p. authorize those family members and other adults who will be given priority to visit consent with your ability to receive visitors; and
q. make known your wishes regarding anatomical gifts. You may document your wishes in your health care proxy on a donor card, available from the center.

Authorization for Access to Patient Information Through HEALTHeLINK™

Patient First Name		
Patient Last Name		
Date of Birth / /	**Patient Address** _____ _____	**Gender** ☐ Male ☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at http://wnyhealthelink.com/.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☒ **1. YES**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): Participant's address or phone number:
☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)**	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): Participant's address or phone number:
☐ **4. NO, EXCEPT IN AN EMERGENCY**	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐ **5. NO, EVEN IN AN EMERGENCY**	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X_____

Signature Date

/ /2020

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other_____

The Chautauqua Center

Entity Consent Received By

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information About You Are Included.** If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. 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
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted disease

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other eHealth organizations that exchange health information electronically. A complete list of current Information Sources is available from HEALTHeLINK at http://wnyhealthelink.com or by calling 716- 206-0993 ext. 103.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at http://wnyhealthelink.com/physicians-staff/current-participants/participating-healthelink-providers/ or by calling 716-206-0993 ext. 103 if you want a hard copy, which will be provided at no charge within five (5) business days of the request.

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 one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at http://wnyhealthelink.com; or call HEALTHeLINK at 716- 206-0993 ext. 103; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

6. **Re-disclosure of Information.** Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity, our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision, they are not required to return your information or remove it from their records.

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Acknowledgement of **HIPAA**
(Health Insurance Portability and Accountability Act)

I hereby acknowledge that I have received a copy of The Chautauqua Center's notice of privacy practice.

_____ _____
PRINT PATIENT NAME **DATE OF BIRTH**

Please list your emergency contact.

_____	_____	_____	_____
Name	Relationship	Date of Birth	Phone

Please list all authorized people whom you give permission to discussions your treatment/ account.

_____	_____	_____	_____
Name	Relationship	Date of Birth	Phone
_____	_____	_____	_____
Name	Relationship	Date of Birth	Phone

FOR MINOR PATIENTS ONLY:
Please list all authorized people whom you give permission to bring child to appointments. All authorized listed will receive medical information at the time of appointment however, the person accompanying your child will not have the authority to sign the permission for vaccine administration.

_____	_____	_____	_____
Name	Relationship	Date of Birth	Phone
_____	_____	_____	_____
Name	Relationship	Date of Birth	Phone

_____ _____ _____
Signature (If minor, Parent/Legal Guardian Signature) Relationship **Date**

_____
Print Name