



**CONSENT FOR TREATMENT AND
AUTHORIZATION FOR RELEASE OF INFORMATION**

PATIENT NAME: _____
(Please print)

DATE OF BIRTH: _____ MEDICAL RECORD # _____

CONSENT FOR TREATMENT

I hereby authorize Syracuse Community Health Center, Inc. to provide ambulatory services to me (or to my child if I am consenting to this agreement as a parent, custodial parent or legal guardian to a minor child). I hereby consent to the performance of such diagnostic studies, medical treatment, and supportive services as may be ordered or performed by licensed or authorized clinical providers, including, but not limited to, routine and/or emergency examinations and procedures, obtaining specimens, injection of medications and immunizations for myself or a minor child as may be deemed necessary.

Patient's Signature
(Parent or Legal Guardian if Patient is a Minor)

Relationship to Patient

Witness

Date

Department

Title

If this treatment consent/authorization is for someone other than myself, I hereby authorize the following individual(s) to bring the patient to the Health Center for treatment:

Name	Relationship to Patient	Date of Birth
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AUTHORIZATION FOR RELEASE OF INFORMATION / CONSULTATION REFERRAL /
MINOR AUTHORIZATION

I hereby authorize and consent to the use of my (or the above named individual for whom I am the parent, custodial parent or legal guardian) health information for treatment, payment, and Syracuse Community Health Center, Inc.'s (SCHC) healthcare (business) operations and authorize SCHC to release any information necessary regarding my/the patient's diagnosis and treatment to my insurance company regarding this and subsequent visits to SCHC, as well as providing a copy of my/the patient's medical records/x-rays to the SCHC provider or other provider or agency to which I may be referred to for consultation. I consent to SCHC's access of my/the patient's health information maintained by other treatment providers for purposes of continuity of care. I further consent to the sharing of my/the patient's health information between SCHC and any other provider or agency to which I/the patient have been referred who are involved or may potentially be involved in my/the patient's care, as necessary, for coordination and management of my/the patient's continuing care needs. I also authorize the release of any contact information I provide to SCHC (including home, work and cellular telephone numbers, address, and e-mail address) to the health care professionals rendering care on my/the patient's behalf, including any billing service, collection agency, or attorney who may work on behalf of these entities. In order to perform the necessary treatment, payment and health care business operations associated with my/the patient's care, including patient outreach and appointment reminders, I authorize SCHC and the health care professionals rendering my/the patient's care, as well as any billing service, collection agency, or attorney who may work on behalf of these entities, to contact me using any methods of contact I have provided to SCHC, including contacting me on my cellular phone and/or home phone using an automatic telephone dialing system, an artificial pre-recorded voice, or other computer-assisted technology, or by e-mail, text message or other form of electronic communication. This authorization will remain in effect until all account balances related to this encounter have been fully satisfied.



I understand that if I am a minor receiving contraceptive counseling, pregnancy testing services and/or supplies that I MUST sign an authorization for these services and I understand that parental consent or knowledge is NOT required. To improve the efficiency and effectiveness of the health care system, SCHC complies with all aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

I understand that if I (or the above-named individual for whom I am the parent, custodial parent or legal guardian) am in need of a referral for community services, including the Onondaga County Department of Health, Onondaga County Department of Social Services and WIC, this authorization allows the exchange of medical information with agents of those community service(s). I understand that as part of SCHC's comprehensive ambulatory care services, my medical record information (and/or that of my minor child) is shared between SCHC's provider teams and the Regional Perinatal Data System for Onondaga County. If I am a patient aged 19 or older, I consent to my immunization information and identifying demographic information being placed in the New York State Immunization Information System (NYSIIS). The immunization information will be released to (1) the patient, if over 18 years of age; (2) the parent, custodial parent or legal guardian of a minor; (3) their insurance company; (4) their school or licensed daycare; (5) the local and state health departments; and/or (6) to a medical provider authorized to provide medical care for me and/or my child. I understand that if I am a patient aged 19 or older, I can withdraw from NYSIIS at any time with notification to my medical care provider. I understand that my child's immunization information will be disclosed to the NYSIIS and my child's lead records will be shared by the Central New York Immunization Registry. I hereby release and hold SCHC harmless for loss or any damage to any personal belongings while a patient at SCHC.

HEALTH INFORMATION EXCHANGE AND CONSENT

I may choose whether or not to allow SCHC to obtain access to my medical records through **Health_eConnections** (or any successor), a Health Information Exchange Organization. If I give consent, my/the patient's medical records from different places where I/the patient obtain health care can be accessed using a statewide computer network. **Health_eConnections** 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. The choice I make on this form will NOT affect my ability to get medical care. The choice I make on 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.

I understand that I may complete this consent now or in the future. I may also change my decision at any time by completing a new consent form. I request that health information regarding my/the patient's care and treatment be accessed as set forth below:

Please check ONE box to the left of your choice:

- I GIVE CONSENT for SCHC to access ALL of my electronic health information through **Health_eConnections** to provide health care services (including emergency care).
- I DENY CONSENT for SCHC to access my electronic health information through **Health_eConnections** for any purpose, *even in a medical emergency.*

To learn more and for full details of the consent process, or if you wish to deny consent for all provider organizations and health plans participating in **Health_eConnections**, or to access to your electronic health information through **Health_eConnections**, you may do so by visiting the **Health_eConnections** website at <http://healthconnections.org/> or calling **Health_eConnections** at 315.671.2241 ext. 5. Details about the information accessed through **Health_eConnections** is attached to this form.

TELEHEALTH / TELEPHONIC VISITS

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. This may include services provided via a two-way electronic audio-visual communication technology, or visits conducted over the telephone. I understand that I have the following rights with respect to Telehealth visits:

1. The right to refuse to participate in services delivered via telehealth at any time and to be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;



2. The right to be informed and made aware of the role and location of the practitioner conducting the visit and to coordination with other qualified professional staff who will be responsible for follow-up or ongoing care;
3. The right to be informed of the risks associated with a telehealth visit, including that the information transmitted may not be sufficient because of technological glitches or the lack of hands-on care, and to have all questions answered regarding the telehealth equipment and technology;
4. The right to have staff immediately available in the event of an emergency;
5. The right to be informed of all parties who will be present at the other end of the telehealth transmission; and
6. The right to select another provider, though selecting another provider could result in a delay in service and the potential need to travel for a face-to-face visit.
7. The laws that protect privacy and the confidentiality of health information also apply to telehealth. The information captured will be maintained, stored and safeguarded in the same manner as with any face-to-face interaction between a patient and a healthcare provider.

PAYMENT TERMS

I understand that payment is due at the time of service. If SCHC participates with my insurance company or the insurance company of my minor child, I am responsible for any co-payments and/or deductibles for all covered charges. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) and/or Title XIX of the Medicaid Act is correct. I request that payment for authorized services be made on my behalf directly to SCHC. Should any account become past due, I understand that SCHC may send my account or that of my minor child to a collection agency.

VIDEOTAPING/PHOTOGRAPHY

I acknowledge and understand that closed-circuit monitoring, videotaping and photography of patient care may be used for internal organizational purposes, including educational, clinical, healthcare operations and/or safety related purposes. I hereby consent to the use of any such recordings or photographs for the above referenced internal business purposes. I further understand that I have the right to withdraw such consent at any time.

I have read this form in its entirety, or it has been read to me, and I fully understand these statements. I am either the patient, or have the legal authority on behalf of the patient to execute this form and accept its terms, and all information provided is accurate and complete to the best of my knowledge. My questions about this form have been answered and I understand that I may request a copy of this form be provided to me.

Patient's Signature <i>(Parent or Legal Guardian if Patient is a Minor)</i>	Date
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Witness	Date
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Department	Title
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Details about the information accessed through Health_eConnections and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used 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 SCHC may access ALL of your electronic health information available through Health_eConnections. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

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. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Health_eConnections. You can obtain an updated list at any time by checking Health_eConnections website at <http://healthconnections.org/> or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Health_eConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 SCHC at 315-476-7921; or visit Health_eConnections website at <http://healthconnections.org/>; 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/>.

7. **Re-disclosure of Information.** Any organization(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.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as Health_eConnections ceases operation. If Health_eConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **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. Organizations that access your health information through Health_eConnections 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.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.