SCHOOL BASED HEALTH PROGRAM REGISTRATION

Today's Date:_____

Patient Information

Child's First Name:_____ Child's Last Name: _____Child's Middle Initial: _____

Child's School: _____ Grade:_____

Child's Assigned Sex: _____ Child's Preferred Gender: _____

Child's Date of Birth:_____ Child's Social Security Number: _____

Home Address:_____

Primary Phone Number:_____Cell Phone Number: _____

Can we text you with routine reminders? ☐ Yes ☐ No

Parent/Legal Guardian Name:_____

Parent Date of Birth: _____ Relationship to Child: _____

Email Address: _____

Insurance Information

Insurance: ☐Commercial ☐ Uninsured Medical Insurance Company: _____

☐Medicaid ☐CDPHP ☐ Fidelis ☐MVP ☐United Healthcare ☐Empire Plan ☐Empire BCBS

Cardholder Name: _____ Policy Number: _____Group: _____

Secondary Insurance: ☐ Yes ☐ No If Yes, Policy Number: _____

Primary Care Provider's Name: _____Phone Number: _____

Date of Last Physical: _____ ☐ Check here if you've included a copy of your child's last physical

Preferred Pharmacy: _____ Pharmacy Address: _____

Name of Child's Dentist: _____ Date of Last Dentist Appointment: _____

Emergency Contact Information

We require the name, address, and phone number of 2 contacts who can be called if parent/guardian are unavailable.

Name of Contact: _____ Phone: _____

Alternate Number: _____ Relationship to Child: _____

Name of Contact: _____ Phone: _____

Alternate Number: _____ Relationship to Child: _____

Medical Information

Please list any medication that your child takes on a regular basis. (pills, sprays, inhalers, etc.).

Medication	Dosage	When do they take it	Why do they take it

Is your child taking a multivitamin: ☐Yes ☐No Is your child taking a fluoride supplement? ☐Yes ☐No

Does your child have ANY allergies: ☐Yes ☐No If yes, please list and explain reaction below:

_____

Has your child ever been diagnosed with ANY of the following conditions: ☐Asthma ☐Diabetes ☐ADHD

Does your child have ANY serious illness or medical conditions? ☐Yes ☐No

If yes, please explain and provide most recent date:_____

Has your child had ANY serious injuries or accidents? ☐Yes ☐No

If yes, please explain and provide most recent date:_____

Has your child had ANY surgery? ☐Yes ☐No

If yes, please explain and provide most recent date:_____

Has your child EVER been hospitalized overnight? ☐Yes ☐No

If yes, please explain and provide most recent date:_____

Does anyone in your family smoke? ☐Yes ☐No If yes, where: ☐Inside ☐Outside

Are there any health, social, or academic concerns for your child that you would like to make us aware of? ☐Yes ☐No

If yes, please explain: _____

AS A REMINDER, YOU WILL NOT BE BILLED FOR ANY SERVICES THAT YOUR CHILD RECEIVES AT WHITNEY YOUNG HEALTH SCHOOL-BASED HEALTH CENTER. The SBHC will bill the student's health insurance for services provided on site at the SBHC. However, services received outside the SBHC (such as lab work) are subject to fees. **

The staff of the School-Based Health Center considers parental/guardian involvement essential in keeping children healthy and will encourage each student to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time.

Parent/Guardian Signature: _____ Name: _____

Relationship to Student: _____ Date: _____

SCHOOL-BASED HEALTH PROGRAM CONSENT FOR HEALTH SERVICES

The following services may be provided to your child at the School-Based Health Center (SBHC):

1. Comprehensive physical exams, including those for school sports
2. Lab tests and screenings when necessary, to detect illness or infection (i.e., strep throat)
3. Age-appropriate immunizations (Vaccine Information Statements, or VIS, can be found at www.cdc.gov/vaccines/hcp/vis)
4. Assessment and treatment for acute and chronic conditions, minor injuries and emergency care
5. Health and nutrition education and counseling
6. Prescriptions
7. Referrals to outside specialists for services not provided at the SBHC
8. Oral Health screening and fluoride varnish

I hereby give consent in my absence for **MY CHILD**, _____, to receive health care services including, but not limited to any age-appropriate care provided by the professional staff of the Whitney Young Health (WYH) SBHC.

- I further give consent to the staff of the SBHC to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, if necessary, you may contact our current or past healthcare providers to share information regarding my child's treatment and you may exchange medical information as needed with the site nurse for coordination of care purposes.
- I hereby give consent to the staff of the SBHC to obtain copies of my child's most recent physical exam and immunization records from their primary care providers.
- I further consent to the staff of the SBHC to obtain my child's medication history from external sources to be better informed about potential medication issues and use that information to improve safety and quality of care.
- I hereby give consent for my child to receive a physical exam and/or wellness visit by the professional staff of the SBHC.
- I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier for services rendered by WYH's SBHC.
- I understand and accept responsibility for costs associated with services provided outside of the SBHC Program.
- I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease and reproductive health or outpatient mental health services.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms I have received a copy of Whitney Young Health Privacy Practices, as well as the Patient Bill of Rights and Patient Responsibilities.

Signature: _____ **Name:** _____

Relationship to Child: _____ Date: _____

*****THIS FORM MUST BE SIGNED FOR YOUR CHILD TO ENROLL IN PROGRAM**

SIGNED FORMS ARE VALID AT WYH SBHC LOCATION UNLESS REVOKED IN WRITING BY THE PARENT OR LEGAL GUARDIAN

WHITNEY YOUNG HEALTH

ANNUAL SUPPLEMENTAL INFORMATION

Federal regulations require that we obtain this information annually in order to document we are serving low and moderate income households. The Patient/Guardian should complete this form including all persons residing in their household, regardless of whether or not they are related. The information in this report will be retained for the purposes of the aggregate reporting. Completion of this form is voluntary.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITHOUT YOUR PERMISSION EXCEPT AS REQUIRED BY LAW TO CONFIRM INCOME ELIGIBILITY OF PARTICIPANTS IN FUNDED PROGRAMS.

Patient Name: _____ Date of Birth: _____

Home address: _____

RACE:

☐ **American Indian or Alaskan Native** (includes persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.)

☐ **Native Hawaiian** (Persons having origins in any of the original peoples of Hawaii.)

☐ **Asian** (Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Other Pacific Islander** (Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, or other Pacific Islands of Micronesia, Melanesia, or Polynesia.

☐ **Black or African American** ☐ **White** ☐ **Not listed**

ETHNICITY:

☐ **Hispanic or Latino** (Persons having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central America, and or Other Spanish origins.)

☐ **Non Hispanic or Latino** ☐ **Not listed**

LANGUAGE:

Primary Language: _____

Do you require interpretation services? ☐ Yes _____ Language required ☐ No

UNITED STATES VETERAN: ☐ **YES** ☐ **NO**

GENDER:

☐ Male ☐ Transgender Male / Female-to-Male ☐ Other

☐ Female ☐ Transgender Female / Male-to-Female ☐ Choose not to disclose

SEXUAL ORIENTATION:

☐ Lesbian or Gay ☐ Bisexual ☐ Don't know

☐ Straight (not lesbian or gay) ☐ Something else ☐ Choose not to disclose

ANNUAL HOUSEHOLD INCOME:

☐ $_____ ☐ Choose not to disclose

Number of family and non-family members living in your household:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ _____

I certify the above information is true and correct to the best of my knowledge.

Patient/Guardian signature: _____ Date: _____

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM

Whitney M. Young, Jr. Health Center

In this Consent Form, you can choose whether to allow Whitney Young Health to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (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 Whitney Young Health 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, Whitney Young Health 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, Whitney Young Health 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.

Please carefully read the information on both pages of this form before making your decision.

You have two choices:

☐ **I GIVE CONSENT for Whitney Young Health to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for Whitney Young Health to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____

Print Name of Child | Date of Birth | Date

_____ _____

Signature of Child or Child's Legal Representative | Print Name of Legal Representative (if applicable)

_____

Relationship of Legal Representative to Child (if applicable)

Hixny.org

Details About Patient Information in Hixny and the Consent Process

How Your Information Will Be Used:
Your electronic health information will be used by Whitney Young Health 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.

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 your health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included:
If you give consent, Whitney Young Health 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

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

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

Who May Access Information About You, If You Give Consent:
Only these people may access information about you: doctors and other health care providers who serve on Whitney Young Health's medical staff who are involved in your medical care; health care providers who are covering or on call for Whitney Young Health's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information:
There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Whitney Young Health at: (518) 465-4771; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information:
Any electronic health information about you may be re-disclosed by Whitney Young Health to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

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

Withdrawing Your Consent:
You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Whitney Young Health. 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) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

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

We Welcome Your Child to Our School-Based Health Center!

- Please fill out the attached consent form and health questionnaire to enroll your child.
- You are always welcome and encouraged to attend appointments with your child.
- Your child can receive immunizations required for school here.
- Your child can use the SBHC for urgent care when they are sick.
- Your child can receive a physical with us or you can provide one from another doctor.
- Your child can have a primary doctor that is not from Whitney Young Health and still enroll in SBHC.
- We can help manage your child's health conditions, such as asthma.
- We work with the school nurse; we do not replace them.
- There is never an out-of-pocket cost for SBHC services.
- Your child is enrolled as long as they attend this school or you choose to dis-enroll them.
- You have 24-hour access always. If school is not in session, call Whitney Young Health at **518-465-4771**.

Please call SBHC at 518-573-2556 with any questions.

To contact your child's School-Based Health Center office, please call the number below.

Giffen Elementary
518-475-6659

Albany High School
518-475-6306

Sheridan Prep
518-475-6708

Watervliet City School District
518-629-3270

We look forward to serving your child!

PATIENT BILL OF RIGHTS

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

1. Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor;
2. Be treated with consideration, respect and dignity including privacy in treatment;
3. Be informed of the services available at the center;
4. Be informed of the provisions for o -hour emergency coverage;
5. Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. Receive an itemized copy of his/her account statement, upon request;
7. Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. 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 a minimum, the provision of information concerning the speci c 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;
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;
10. Refuse to participate in experimental research;
11. 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;
12. Express complaints about the care 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 ndings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satis ed by the center response, the patient may complain to the New York State Department of Health;
13. Privacy and con dentiality of all information and records pertaining to the patient's treatment;
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;
15. Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm access ;
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;
17. When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center;
18. View a list of the health plans and the hospitals that the center participates with; and
19. Receive an estimate of the amount that you will be billed after services are rendered.

PATIENT RESPONSIBILITIES

Providing patients with the best care possible is a collaborative effort of provider and patient and family. In addition to the services, rights and privilege afforded to patients by Whitney Young Health, patients themselves are also requested to adhere to the following "patient responsibilities" to ensure the best overall health care services.

Provide Information:

- Give completed and accurate medical information to Whitney Young Health staff on the health questionnaire annually and when staff call for information.
- Provide any change of address or telephone number when they occur.

Participate:

- Be involved in your child's care as a team member with the provider/medical assistant. Ask questions to fully understand. It may help to write down your questions prior to care.
- Follow treatment advice given.
- Adhere to all Whitney Young Health rules and regulations.

Appointments and Tips:

- The laboratory services are billed separately and are NOT part of Whitney Young Health School-Based Health Center or the Mobile Unit. If a bill is received please give it to a Whitney Young Health staff member.
- Allow your provider 7 business days to complete all forms.
- Allow your provider 3 business days for prescription refills.

Emergencies:

- For any emergency that is life threatening, e.g. chest pains, shortness of breath, uncontrolled bleeding, **CALL 911 or GO TO AN EMERGENCY ROOM IMMEDIATELY**.
- Whitney Young Health has coverage 24 hours a day, 7 days a week, including holidays at **(518) 465-4771**
- If Whitney Young Health is closed for the day, calls will be transferred to our answering exchange.
- A patient directed to an emergency facility must contact their primary care provider within 48 hours of the visit to an emergency room or admission to the hospital to coordinate follow up care.

Whitney M. Young, Jr. Health Center, Inc.

NOTICE OF PATIENT PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Health Information Technology for Economic and Clinical Health of 2009 (HITECH) and the Omnibus Rule of 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Whitney Young Health (WYH) is dedicated to maintaining the privacy of your "Protected Health Information" (PHI). PHI is any individual identifiable health information we create or receive that relates to your past, present or future health care or medical condition. PHI includes paper, electronic and oral data.

We are required by law to maintain the confidentiality of PHI. We also are required to provide you with this notice of our legal duties and the privacy practices that we maintain concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Our practice will post the current Notice of Privacy Practices on our Website at **www.wmyhealth.org**, and you may request a copy of our Notice at any time.

B. WYH MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

1. Treatment. Our practice may use your PHI to provide, coordinate and manage your health care. We may disclose medical information about you to other doctors, nurses, technicians, clinical laboratories, imaging companies, or other personnel in an unrelated organization for purposes related to your treatment including care coordination. For example, we may refer you to a specialist and share your PHI with that provider. Or we might disclose your PHI to a pharmacy when we order a prescription for you.

2. Payment. Our practice may use and disclose your PHI 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 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 PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI 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 PHI to other health care providers and entities to assist in their health care operations.

4. Business Associate. We may disclose information to a person or entity we contract with to perform some of our business functions-for example, a billing service or attorney. Business associates and sub-contractors are held to the applicable provision of HIPAA standards.

5. Appointment Reminders and Treatment Options. Our practice may use and disclose your PHI to contact you and remind you of an appointment in a generic manner and to inform you of potential treatment options or alternatives.

6. Family/Friends. Our practice may release directly relevant PHI to a family member or friend that is involved in your care, helps pay for your care or who assists in taking care of you, unless you provide written instructions not to. Similarly, after your death, relevant disclosures may be made to these same people. HIPAA protection is eliminated 50 years after a patient's death.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority for you before we take any action.

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

8. Alcohol and Substance Abuse, Mental Health and HIV PHI. Disclosure of information related to Alcohol and Substance Abuse, Mental Health, and HIV treatment is further protected in by Federal Regulation 42 CFR. Specific authorization for release of these treatment records is required. WYH uses NYS DOH for 5032 for appropriate authorization to release these treatment records.

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. Childhood Immunizations. WYH may disclose immunizations to schools required to obtain proof of immunizations prior to admitting the student as long as we have and document in the EMR the parent's or legal guardian informal agreement to the disclosure.

2. Public Health Risks. WYH may disclose your PHI for public health activities and purposes. For example, we may disclose information to a public health authority that is authorized to receive such information for the purpose of controlling disease, injury or disability. WYH may also disclose your PHI to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law or rule permits us to do so.

3. Abuse or Neglect. We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to the governmental entity or agency authorized to receive such information.

4. Health Oversight Activities. Our practice may disclose your PHI 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.

5. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

6. Law Enforcement. We may release PHI 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; or
- 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).

7. Research. We may disclose your PHI to researchers if an institutional review board reviews and approves the research proposal and protocols to ensure your privacy.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI 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.

9. Specialized Governmental Functions. Our practice may use or disclose PHI for specialized governmental functions, such as disclosing information about a member of the armed services to the military to assure the proper execution of a military mission, or disclosing information about inmates to a correctional facility for security, continued health care or safety or other important purposes.

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

11. Marketing Communications. WYH must obtain your written authorization to market a third party's product or service to you except when:

- WYH receives no compensation for marketing the third party's product or service;
- The communication is face to face;
- The communication involves a drug or biologic that you are currently being prescribed and the payment is limited to reasonable reimbursement of the cost of the communication (no profit);
- The communication involves general health promotion, rather than the promotion of a specific product or service; or
- The communication involves government or government sponsored programs.

12. Sale of PHI. WYH will not sell your data to an outside entity, nor will we permit an outside entity to access your information for purposes of informing you of health-related benefits or services without your explicit written authorization.

13. Fundraising. Our practice may use demographic data, dates of service, department of service, treating provider, outcome information and health insurance information to send you material in connection with our efforts to raise funds. If we do, we will have a clear and conspicuous method to let you know how to opt out of receiving any future fundraising materials.

D. YOUR RIGHTS REGARDING YOUR PHI

Although your health records are the physical property of WYH and the health care providers who created it, you have the following rights with regard to the information contained therein and the following rights regarding the PHI 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 WYH 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 PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict disclosure of your PHI to individuals involved in your care or the payment for your care, such as family members and friends. You must provide us with a written request which states the specific restriction requested and to whom you want the restriction to apply. **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.

Also, if you pay for a service or health care item in full, you may ask us not to share the information for the purpose of payment or our operations with your health insurance. We will honor your request unless required by law. This restriction request must in writing.

3. Inspection and Copies. You have the right to inspect and obtain an electronic or paper copy of the PHI 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 WYH. 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.

4. Amendment. You may ask us to correct 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. You must provide us with written request and a reason that supports your request for amendment. Our practice may deny your request to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI 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. You 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 PHI for non-treatment or operations purposes. All requests for an "accounting of disclosures" must be in writing, state a time period, which may not be longer than six (6) years from the date of disclosure. We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

6. Notice of Breach. You have the right to receive a written notice of a breach of your unsecured PHI by first class mail or by secured email if that is your recorded preference. WYH will send the notice without unreasonable delay and within 60 days of the discovery of the breach.

7. Right to a Copy of This Privacy Notice. You are entitled to receive a paper copy of our notice of privacy practices at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

8. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice by calling **the Corporate Compliance Officer** at 1 (518) 591-4905or sending a letter to the address below. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, DC 20201, calling 1(877)696-6775 or visiting www.hhs.gov/orc/privacy/hipaa/complaints/. **You will not be penalized or retaliated against for filing a complaint**.

9. 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. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Corporate Compliance Officer
920 Lark Drive
Albany, NY 12207
(518) 591-4482

It is the policy of WYH that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.