REGISTRATION FORM

Instructions: Fill in the blanks. Please replace any Incorrect or outdated information.

Patient Information

Patient Name	Gender	DOB	SSN	Race	Ethnicity	Preferred Language

Address	Address Line 2	City, State, Zip

Home Phone	Home Fax#	Cell Phone	Email Address

Employer Name	Employer Address	City, State	Zip	Work Phone

Emergency Contact

Emergency Contact Name	Home Phone	Cell Phone	Work Phone
Emergency Contact Relationship			
Guarantor Name	Relationship	Home Phone	Work Phone

Physician Information

Referring Physician's Name	City, State	Phone
Primary Care Physician Name	City, State	Phone

Insurance Information

PRIMARY Insurance Name	Certificate/Policy #		Group #	Phone
Address	City, State			Zip (primary insurance zip)
Insured's Name	Relation to Insured	Insured's DOB	Effective Date	Expiration Date
SECONDARY Insurance Name	Certificate/Policy #		Group #	Phone
Address	City, State			Zip
Insured's Name	Relation to Insured	Insured's DOB	Effective Date	Expiration Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Northwell Health Physician Partners, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Northwell Health Physician Partners sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

(Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

________________________________ ____________________

Signature of Patient or Authorized Guardian *Date*

Northwell Health® Physician Partners

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PATIENT NAME:	DATE OF BIRTH:	PATIENT IDENTIFICATION NUMBER:
PATIENT ADDRESS:		

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 Northwell Health (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix 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 Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

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.

My Consent Choice. 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. **I GIVE CONSENT** for Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ 2. **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Northwell Health to access my electronic health information through Healthix.

☐ 3. **I DENY CONSENT** for Northwell Health to access my electronic health information through Healthix for any purpose, ***even** in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

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

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 the information accessed through Healthix 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 Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. 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 & diagnoses
   - Birth control and abortion (family planning)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary
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 Healthix. You can obtain an updated list at any time by checking Healthix's website at www.healthix.org or by calling 877-695-4749.
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 Healthix 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 Provider Organization at: 800-894-3226; or visit Healthix's website: www.healthix.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, death or until such time as Healthix ceases operation. If Healthix 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 Healthix 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.

Northwell Health®

Authorization for Release of Health Information Pursuant to HIPAA

PATIENT NAME (PRINT)	DATE OF BIRTH
PATIENT ADDRESS (PRINT AND INCLUDE APT#)	TELEPHONE NUMBER
	EMAIL ADDRESS

I, or my authorized representative, request that health information regarding my care and treatment be accessed, used and/or disclosed as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV*-RELATED INFORMATION** only if I place my initials on the appropriate line in Item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol, drug treatment, or mental health related treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. Name and address of health care provider or entity to release this information:

6a. If you are requesting only laboratory results directly from Northwell Health Laboratories, enter "Northwell Health Laboratories" above. Provide the following information and then go directly to Sections 8, 10, 11, 12 and 13 and sign as indicated below item 13.

Ordering Physician's Name: ____________________

Information to Be Released: Laboratory testing results

Date Of Service: ____/____/____

Authorized Recipient:	☐ Patient	☐ Patient's Designee (or parent of unemancipated minor patient) Name of Designee ____________ Relationship ________

☐ Consulting Physician: Name: ____________________ Telephone: (____) ________

Address: ____________________

The laboratory CANNOT answer any questions in reference to interpretation, diagnosis or treatment of laboratory results. All questions regarding testing and the results will be answered by the PATIENT'S PHYSICIAN ONLY. Reports will generally be available 4 days after ALL laboratory test result are complete.

Result option (select one) ______ ☐ Mail ______ ☐ Fax ______ ☐ Pick-Up (at any Patient Service Center)

Patient or Representative Initials: [ ]

Copy 1 – Patient Medical Record

Copy 2 – Patient or Patient's Personal Representative

Northwell Health®

Authorization for Release of Health Information Pursuant to HIPAA

7. Name, address, telephone and fax numbers of person(s) or category of person to whom this information will be sent:

Full Name (Print):	Phone #:
Full Address (Print and include Apt or Suite #):	Fax #:
	Email Address:

8. (a).Specific information to be released:

☐ Medical Record Abstract ☐ Medical Record from (insert date) ______________ to (insert date) ______________

☐ Designated Record Set ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.

☐ Other: ________________________________

____

Include: (Indicate by initialing)

________ **Alcohol/Drug Treatment**

________ **Mental Health Related Information**

________ **HIV-Related Information**

8. (b).**Authorization to Discuss Health Information**

☐ By initialing here _________ I authorize ________________________________
Initials Name of individual health care provider

to discuss my health information with the individual listed: ________________________________
Individual Name

9. Reason for release of information: ☐ At request of individual ☐ Other: ______________	10. Date or event on which this authorization will expire:
11. Printed name and signature of person signing form:	12. Authority to sign on behalf of patient or relationship to patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

________________________________ ________________________________
Patient/Agent/Relative/Guardian* (Signature) Date / Time Print Name Relationship if other than patient

____
Telephonic Interpreter's ID # Date / Time
OR

________________________________ ________________________________
Signature: Interpreter Date / Time Print: Interpreter's Name and Relationship to Patient

________________________________ ________________________________
Witness to signature (Signature) Date / Time Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Internal Use Only - Student Immunization Authorization Consent provided by

Consent provided by: ________________________________ Relationship to Patient: ______________

Name of HIM Staff Member who obtained verbal consent: ______________________ Date Processed: __________

Internal Use Only - For Northwell Health Laboratories Use Only:

Date: ____/____/____; Time: ____:____; Personnel Name: ______________________; Accession #: __________