WELCOME TO YOUR MEDICAL HOME

A Medical Home is all about you. Caring about you is the most important job of your Patient Centered Medical Home. In this personal model of health care, your primary provider leads the team of health care professionals that collectively takes responsibility for your care. They make sure you get the care you need in wellness and illness to heal your body, mind and spirit.
Your personal provider and an extended team of health professionals build a relationship in which they know you, your family situation, your medical history and health issues. In turn, you come to trust and rely on them for expert, evidence-based health care answers that are suited entirely to you or your family.

THE MEDICAL HOME ADVANTAGE

There are many benefits to being in a Medical Home:

- Comprehensive care means your medical home helps you address any health issue at any given stage of your life
- Coordination of care occurs when any combination of services you and your provider decide you need are connected and ordered in a rational way, including the use of resources in your community
- Continuous care occurs over time and you can expect continuity in accurate, effective and timely communication from any member of your health care team.
- Accessible care allows you to initiate the interaction you need for any health issue with a physician or other team member through your desired method (office visit, phone call, or electronically) and you can expect elimination of barriers to the access of care and instructions on obtaining care during and after hours.
- Proactive care ensures you and your provider will build a care plan to address your health care goals to keep you well, plus be available for you when you get sick.

WHO IS YOUR MEDICAL HOME TEAM?

Your team may include a doctor, physician assistant, nurse practitioner, licensed practice nurse, medical assistant or health educator, as well as other health professionals. These professionals work together to help you get healthy, stay healthy, and get the care and services that are right for you. When needed, your personal doctor arranges for appropriate care with qualified specialists.

WE WANT TO LEARN ABOUT YOU

- We want to get to know you, your family, your life situation, and preferences, and suggest treatments that make sense for you.
- We want to treat you as a full partner in your care
- We want to communicate effectively with you
- We want to give you time to ask questions and we want to answer them in a way you understand
- We want to make sure you know and understand all of your options for care
- We want to help you decide what care is best for you. Sometimes more care is not better care. We want to ask you for feedback about your care experience.

WE WANT TO SUPPORT YOU IN CARING FOR YOURSELF

- We want to make sure you develop a clear idea of how to care for yourself.
- We want to help you set goals for your care and help you meet your goals one step at a time
- We want to encourage you to fully participate in recommended preventive screenings and services
- We want to give you information about classes, support groups, or other types of services to help you learn more about your condition and stay healthy

HERE IS WHAT YOU CAN DO

ACTIVELY PARTICIPATE IN YOUR CARE

You are the most important member of the medical home team.

- Understand that you are a full partner in your own health care.
- Learn about your condition and what you can do to stay as healthy as possible.
- As best you can, follow the care plan that you and your medical team have agreed is important for your health.

COMMUNICATE WITH YOUR MEDICAL HOME TEAM

- Bring a list of questions to each appointment. Also, bring a list of any medicines, vitamins, or remedies you use.
- If you don't understand something your doctor or other member of your medical home team says, ask them to explain it in a different way.
- If you get care from other health professionals, always tell your medical home team so they can help coordinate for the best care possible
- Talk openly with your care team about your experience in getting care from the medical home so they can keep making your care better.

DEMOGRAPHICS:

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____

CITY, STATE:_____ ZIP CODE:_____

TELEPHONE NUMBERS-HOME:_____WORK: _____CELL: _____

E-MAIL ADDRESS: _____SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____ OCCUPATION:_____

INSURANCE COMPANY:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

NAME OF INSURED (IF DIFFERENT):_____

RELATIONSHIP TO INSURED:_____ DATE OF BIRTH OF INSURED:_____

SOCIAL SECURITY NUMBER OF INSURED:_____

REASON FOR TODAY'S VISIT:_____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:_____

WHOM MAY WE THANK FOR YOUR REFERRAL?_____

Language Spoken	o English o Spanish o Korean o Other Language: _____	**Ethnicity:**	o Decline to State o Hispanic or Latino o Not Hispanic or Latino o Unknown
Race:	o American Indian or Alaska Native o Asian o Black or African American o Native Hawaiian or Other Pacific Islander o White o Other Race: _____	**Marital Status:**	o Single o Married o Other: _____
		Student Status	o Not a Student o Full Time o Part Time
Sexual Orientation:	o Lesbian, gay or homosexual o Straight or heterosexual o Bisexual o Something else, please describe o Do Not Know o Choose Not to Disclose	**Gender Identity**	o Identifies as Male o Identifies as Female o Female to Male o Male to Female o Genderqueer o Additional Gender o Choose Not to Disclose
Gender:	o Male o Female o Other: _____		

Do you have an ADVANCED HEALTHCARE DIRECTIVE? (a legal document in which a you specify what actions should be taken for your health if you are no longer able to make decisions for yourself because of illness or incapacity)

- ○ Health Care Proxy
- ○ Living Will
- ○ Other: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the practitioners of Dr. Scafuri & Associates to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

PATIENT'S SIGNATURE **DATE**

REFERRALS TO OTHER PROVIDERS:

You have elected to receive services from practitioners of Dr. Scafuri & Associates. One of the practitioners of Dr. Scafuri & Associates is referring you to or coordinating services from another provider. These services are required as part of your treatment during your office visit. These services may include:

Radiology Services	Laboratory Services	Pathology Services	Diagnostic Services

If you are having a scheduled hospital admission or outpatient hospital services/procedures: Physicians' services can be arranged by the office staff or practitioners of Dr. Scafuri & Associates during your scheduled hospital admission or outpatient hospital procedure. You should contact the other physician(s) or your health plan to determine if the other physician(s) participates in your health plan.

_____ **I UNDERSTAND THAT THE ABOVE PROVIDERS MAY BE INVOLVED IN MY CARE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO DETERMINE IF THE OTHER PROVIDERS PARTICIPATE IN MY HEALTH PLAN.**

PATIENT'S MEDICAL HISTORY

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY OR CIRCLE NONE		
❑ Alcoholism	❑ Epilepsy	❑ Migraine Headaches
❑ Acid Reflux	❑ Eye Disease	❑ Multiple Sclerosis
❑ Anemia	❑ Glaucoma	❑ Murmur
❑ Arthritis	❑ Gout	❑ Pacemaker
❑ Asthma	❑ Head Injury	❑ Prostate Disease
❑ Bleeding Disorder	❑ Heart Disease	❑ Psychiatric Disease
❑ Cancer _____	❑ Hearing Loss	❑ Rheumatologic Disease
❑ Cataracts	❑ Hepatitis	❑ Seasonal Allergies
❑ Congestive Heart Failure (CHF)	❑ High Blood Pressure/Hypertension	❑ Stomach/Digestive Ulcer
❑ Cardiac Stents	❑ High Cholesterol	❑ Stroke/CVA/TIA
❑ Diabetes	❑ HIV/AIDS	❑ Suicide Attempt
❑ Depression	❑ Inflammatory Bowel Disease	❑ Thyroid Disease
❑ Dementia	❑ Irregular Heartbeat	❑ Tobacco Use
❑ Drug Dependency	❑ Kidney Disease/Stones	❑ Tuberculosis
❑ Emphysema or COPD	❑ Liver Disease	❑ Venereal Disease/STD
Surgeries (with dates): ○ _____ ○ _____ ○ _____	**Recent Hospitalization (with dates):**	**Other Medical History:**

FAMILY HISTORY			
Has any member of your family (parents, grandparents, siblings) ever had the following?			
Illness	**Which family member**	**Illness**	**Which family member**
Cancer (which type)		Stroke	
High blood pressure		Mental illness	
Heart disease		Glaucoma	
Diabetes		Other (please specify)	

CURRENT MEDICATIONS					
NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR ANY OTHER SUBSTANCES

Please list what you are allergic to and the type of reaction you had.

_____

_____

HEATH MAINTENANCE RECORD			
When was your last … (please provide the year)			
Physical Exam		**Female Patients**	
Colonoscopy		Pap Smear	
Gastroenterologist's Name		Last Menstrual Period	
Cardiac Workup		Breast Examination	
Cardiologist's Name		Mammogram	
Eye Exam		Bone Density	
Ophthalmologist's Name		*OB/GYN's Name*	
Chest X-ray		**Social History**	
Male Patients		Alcohol	❑ YES ❑ NO
Prostate Specific Antigen (PSA)		Smoking or Vaping	❑ YES ❑ NO
Urologist's Name		Drug Use	❑ YES ❑ NO
Have you fallen within the last year? ❑ YES ❑ NO **If yes, how many times:**			

VACCINE RECORD			
Name of Vaccine	**Year of Last Dose**	**Name of Vaccine**	**Year of Last Dose**
Flu Vaccine		Pneumonia Vaccine	
Covid-19 Vaccine		Other Vaccines	

PLEASE LIST THE SPECIALISTS YOU ARE SEEING:

Allergies/ENT		Orthopedist	
Cardiologist		Pain Management	
Chiropractor		Podiatrist	
Dermatologist		Psychiatrist	
Endocrinologist		Pulmonologist	
Nephrologist		Rheumatologist	
Neurologist		Surgeon	
OB/GYN		Urologist	
Oncologist/Hematologist		Vascular	
Ophthalmologist		Other	

I AUTHORIZE THE RELEASE OF HEALTH INFORMATION TO DR. SCAFURI & ASSOCIATES FROM ANY SPECIALISTS LISTED ABOVE.

_____ _____

PATIENT'S SIGNATURE **DATE**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA"):

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read, if I so choose) and understood the Notice. I also acknowledge that Dr. Scafuri & Associates uses a HIPAA Compliant and secure virtual remote scribe which allows them to complete their medical charts more quickly and efficiently and focus more on me. If I have any questions about their remote scribe, I agree to let them know.

Sharing Health Information with Family Members and Friends: The following is a list of the names those who I wish to receive my medical information (which includes test results):_____

_____

_____

Please note the following:

- **Only those listed on the line above may call the office and speak with our staff regarding your health;**
- **Include your SPOUSE or PARENT, if you are over 18 years old, if you want our staff to speak with them; and**
- **This form overrides any previous HIPAAs completed.**

_____ _____

PATIENT'S SIGNATURE **DATE**

CREDIT CARD POLICY:

To our valued patients: Thank you for your patronage and we appreciate that you have entrusted us with your health care needs. This is to inform you that your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit, you will be responsible for the bill. You are responsible for deductibles, co-insurances, and copays. If you do not provide us with the correct information to process your claim, such as your insurance card, and the claim is denied, you will be responsible for these charges.

Dr. Scafuri & Associates require a credit card or FSA card on file. This is NOT for copays on the actual date of service you are being seen.

According to your insurance plan, we are required to collect your copays, deductibles, and/or coinsurance. In providing the credit card information below, you authorize payment for services rendered, including copays, co-insurance, deductibles, and/or uncovered services. Once your insurance settles the claim and notifies us of your patient responsibility, balances under **$200.00** will be charged **AUTOMATICALLY**. For patient balances exceeding $200.00, you will be notified by us, prior to your credit card being charged. A receipt for the amount charged will be automatically mailed to your home.

The safety of your personal information is of the utmost importance to us. Please feel confident that all information provided is highly confidential and secure. By signing below, you acknowledge that you have read the Credit Card Policy above, you understand its terms and you accept full responsibility for all services rendered.

_____ _____

PATIENT'S SIGNATURE **DATE**

Name on Card: _____ Card Number: _____

Visa _____ Master Card _____ Amex _____ Discover _____

3-4 Digit Security Code: _____ Billing Zip Code: _____ Exp:_____

Please Indicate Type of Card being Used: _____ FSA/HSA

_____ Debit or Credit

PHYSICIAN PARTICIPATION AND AFFILIATION INFORMATION:

The following is a list of health plans in which the practitioners of Dr. Scafuri & Associates participates: Aetna, Affinity (as specialists ONLY), Amida Care (ONLY Dr. Scafuri as specialists), Community Plan by United HealthCare, Cigna, Elderplan, Emblem GHI and HIP, Empire Blue Cross/Blue Shield, Empire Plan by United HealthCare, EverCare, Fidelis, First Health, HealthCare Partners, MagnaCare, Medicaid (as a secondary insurance plan), Medicare, Multiplan, Oxford (Freedom and Liberty), Tricare, United HealthCare, USFHP, 1199, Most Union Locals, Line of Duty Injury, and No Fault. **WE NO LONGER TAKE WORKER'S COMPENSATION.** ***If you do not see your insurance company listed, please let us know.***

The practitioners of Dr. Scafuri & Associates are affiliated with Richmond University Medical Center and Staten Island University Hospital.

This information is also available at: www.DrScafuri.com. If your health plan is not listed here, then the physician DOES NOT participate in your plan, and any services provided may be out-of-network. You should also check with your health plan to confirm that the physician participates in your specific health plan product, even if the health plan is listed above. Estimated charges for out-of-network services are available upon request.

_____ I ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT THE HEALTH PLANS IN WHICH MY DOCTOR PARTICIPATES. I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY OUT-OF-NETWORK COSTS IF MY DOCTOR DOES NOT PARTICIPATE IN MY HEALTH PLAN OR PRODUCT.

FINANCIAL POLICIES:

PATIENTS WITHOUT INSURANCE: If you do not have medical benefits, you must pay at the time of service.
PATIENTS WITH INSURANCE:

1. Our office will accept insurance assignment from a variety of insurance companies in order to help you meet your financial obligation for your treatment.
2. We will also process all claims related to your visit, including any vaccines that have been administered. Therefore, it is necessary for you to sign our assignment of benefits form.
3. Your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit or any other ancillary services received from this office, you are responsible for your bill. Additionally, your co-pay is due before each visit.
4. If you discontinue care for any reason, your total account balance is due and payable immediately. If and when your insurance company sends us payment for services you have paid for, the payment will be returned.
5. In the event your insurance company requires you to obtain a referral for your visit or any other ancillary service received from this office, it is your responsibility to present this referral at the time of your appointment. In the event you do not have one, or the one you have on file has expired, your insurance company will not pay for the services rendered by this office and said payment will become your responsibility.
6. If, at the time of your visit, you do not have the required information to process your claim, such as your insurance card, no fault information or worker's compensation numbers, it is your responsibility to provide this information in a timely manner. If you do not provide this information and the claim is thereby denied, you will be responsible for these charges.

OFFICE POLICIES:

1. Twenty-four (24) hour notice must be given to our office for all referrals that a patient needs to see a specialist.
2. Prior Authorizations and Pre-certifications require up to seven (7) business days to be obtained.
3. In order for disability papers to be completed, an office visit is required. Thereafter, it may take up to seven (7) days for them to be finished.
4. If your insurance company requires a referral for you to see Dr. Scafuri & Associates as a specialist, the referral must be submitted at the time of your visit. If you do not have a referral at that time, you must pay for the office visit in cash or credit card. Upon receipt of a valid referral, your money will be refunded. Furthermore, if your referral has expired, it is your responsibility to obtain a new referral and submit that referral at the time of your office visit.

Again, if it is not submitted, the office visit must be paid for in cash or credit card and your money will be refunded when the valid referral is submitted.

5. Medication that is considered a controlled substance will not be prescribed by the doctor on your initial visit. Also, an office visit is required for antibiotics to be prescribed.
6. Twenty-four (24) hour notice must be given to cancel your appointment. If said notice is not provided you will be billed fifty dollars ($50.00) as a cancellation fee, fifty-one dollars and sixty-three cents ($51.63) is the credit card price.
7. If you had labwork or another test performed, please call the office seven (7) days after to confirm the results were received. Please do not assume that we received your results and all is fine. In some cases, we do not receive any results and there is no way for the doctor or his staff to know that you went for your test unless we are notified.
8. Your co-payment is due at the time of your visit. If you do not have the payment at that time, we will send you a bill, but a ten dollar ($10.00), ten dollars and thirty-two cents ($10.32) credit card price, service charge will be applied.
9. An appointment must be made to review any laboratory results. The doctor will **NOT** give any results over the telephone.
10. Our office does not accept checks as a form of payment for any services rendered. However, in the event, you do pay for a service by check, and that check bounces, you will be responsible for a twenty-five dollar ($25.00), twenty-five dollars and eighty-one cents ($25.81) credit card price, processing fee together with any fees incurred by our office from our financial institution.

VACCINE POLICY:

Please be aware that it is our office policy to collect payment for vaccinations prior to the time the vaccine is administered. We will submit the charge to your insurance company and, in the event we are reimbursed for the ***vaccine***, we will in turn reimburse you. Notably, your reimbursement will be in the form of check no matter how you made the payment for the vaccine. The following is a list of fees for the vaccines that we carry:

VACCINE NAME	CASH PRICE	CREDIT CARD PRICE
TDaP (tetanus)	$75.00	$77.44
B12	$20.00	$20.65
Depo-Medrol	$40.00	$41.30
Hepatitis A Vaccine	$125.00	$129.06
Hepatitis B Vaccine	$150.00 each (3 doses)	$145.88 each (3 doses)
Haemophilus B Conjugate Vaccine	$50.00	$51.63
HPV 9	$300.00 each (3 doses)	$309.75 each (3 doses)
Influenza Vaccine Flublock	$75.00	$77.44
Flurix/Fluzone	$75.00	$77.44
High Dose Flu (65 years old and older)	$75.00	$77.44
Meningococcal/Menquadfi	$175.00	$180.69
MMR	$100.00 each (2 doses)	$103.25 each (3 doses)
Polio Vaccine	$100.00	$103.25
Pneumonia Vaccine Prevnar 13	$200.00	$206.50
Prevnar 20	$350.00	$361.38
Pneumovax	$125.00	$129.06
PPD	$30.00	$30.09
Rabies Intramuscular	TBA each	TBA each
Shringrix	$225.00 each (2 doses)	$232.31 each (2 doses)
Trumenba	$150.00	$154.88
Twin Rx (Hep A & B Combination)	$175.00	$180.69
Typhoid Vaccine	$150.00	$154.88
Varicella Vaccine	$175.00	$180.69
Yellow Fever Vaccine	$200.00	$206.50

The above cost is per vaccine, so if you are to receive multiple doses of the vaccine, please multiply the cost by the amount of doses. Involved in the administration of the vaccine is an office visit. As a result, in addition to the vaccine payment, you will be responsible to pay your co-pay at the time of your first visit. If your insurance company pays us for your office visit and not the vaccine, your payment will not be returned. Instead, as stated previously, if we are reimbursed by your insurance company for the ***vaccine***, we will in turn reimburse you. We do not accept checks for the payment of vaccines – all payments must be made either in cash or by credit card (Visa, MasterCard, American Express, or Discover Cards). If your insurance company pays for the vaccine, you will be reimbursed the cash price, not the credit card price, regardless of payment method.

If payment is not taken when the vaccine is administered, and your insurance company denies payment, you agree to pay for the cost of each vaccine. Lastly, please be aware that payments and/or explanations of benefits from your insurance company may take more than one month for us to receive. Therefore, we ask for your patience with regard to your refund. By signing this form you acknowledge you have read the above, agree to the terms and acknowledge that you have received the *Center for Disease Control's Vaccine Information Sheet* regarding the vaccine being administered.

DOCUMENTATION PREPARATION POLICY:

Please be aware it is the policy of this office to charge for the preparation of various documents that the physician and/or their staff are asked to complete.

FORM	FEE	CREDIT CARD PRICE
1 Page Disability or Worker's Compensation Forms	$25.00	$25.81
Multiple Page Disability or Worker's Compensation Forms	$50.00	$51,62
CDL License Paperwork	$50.00	$51.62
Chart Copies	$0.75 per page	$0.77 per page
Letters for Any Purpose	$10.00	$10.32
Narrative Report	$400.00	$413.00
School and/or Camp forms	$5.00 each	$5,16
Weight Loss Letters (when weight loss not monitored by our office)	$300.00	$309.75

Some of these fees are required to be paid in addition to the patient having an office visit with a practitioner. The office visit may be paid by your insurance company, but the fee must be paid by the patient in the form of cash or credit card.

Payment must be made BEFORE the document will be prepared. With the exception of a Narrative Report and Chart Copies, all documents will be sent to the place of the patient's choice within one (1) week. The time it will take for the preparation of the Narrative Report and the Chart Copies are based on a case by case basis.

_____ BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ THE ABOVE POLICIES, YOU UNDERSTAND THE TERMS, AND YOU ACCEPT FULL RESPONSIBILITY FOR ALL SERVICES RENDERED.

Healthix

Company Name
Address
Phone Number

New York State Department of Health

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 _____ (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 to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

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 _____ to access ALL of my electronic health information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for _____ to access my electronic health information through Healthix for any purpose.

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
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test

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 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: _____; 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.

Citywide Immunization Registry
We help you call the shots!
www.nyc.gov/health/cir

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Mary T. Bassett, M.D., M.P.H., Commissioner
nyc.gov/health
NYC Health
Phone: (347) 396-2400
Fax: (347) 396-2559

Health Care Providers may document verbal voluntary consent or adapt this sample form for use.

Consent for Participation in Citywide Immunization Registry (CIR)

for individuals 19 years of age and older

The New York Citywide Immunization Registry (CIR) is a confidential, computerized system that allows authorized users access to a person's immunization records. Strict federal and state laws protect the privacy of personal information in the system. Here are some benefits of participating in the CIR:

- Your health care provider can use the CIR to ensure that you receive all needed immunizations.
- The CIR provides you with a permanent and easily accessible record of your immunizations.

Participation in the CIR is voluntary for people 19 and older, so immunizations you receive after 18 years of age will not be included unless you give consent. If you want to participate, please carefully read the statement below and sign in the space provided. For additional information about this consent, please call (347) 396-2400.

Declaration of Consent

I give my consent for _____ (name of doctor or organization) to release my immunization(s) and identifying information to the New York Citywide Immunization Registry (CIR). I understand the purpose of the CIR is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in the CIR may be released to the following: myself, my health insurance organization, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to participate in the CIR. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by the CIR with my consent will remain in the CIR if I later choose to withdraw my consent. However, future immunizations will not be recorded in the CIR.

_____	_____
Print Name	Date of Birth
_____	_____
Signature	Date