Community Care Physicians Pediatric Patient Registration Form

Date: _____ **Patient ID#:** _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____/_____/_____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Legal Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: ( ) _____

Cell #: ( ) _____ Preferred daytime phone: □ Home □Work □ Cell

Date of Birth: _____/_____/_____ Gender: □ Male □ Female □ Other _____

E-mail Address: _____ **Would you like to participate in the patient portal?**
□ Yes □ No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
□ American Indian/Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ Black/African American
□ White
□ Other

Ethnicity: Select One
□ Hispanic/Latino
□ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____/_____/_____

Emergency Phone: ( ) _____ Relationship to Patient: _____

Mother's maiden name _____
First Name Maiden Name

Primary Care Physician: _____ Referring Physician: _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

□ E-Mail (when available) □ Text □ Office may leave a message at home

Please Complete Page 2

Community Care Physicians Pediatric Patient Registration Form

FINANCIALLY RESPONSIBLE PARTY

In accordance with Community Care Physicians' Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. ***Co-pays are due and expected at time of service.***

Financially Responsible Parent/Guardian's Last Name _____ First _____

Relationship to Patient □Mother □Father □Other: _____

Address □ Same as Above Street: _____ City/State/Zip _____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # ( )_____

Date of Birth ____/_____/_____ Guarantor: □ Yes □ No

Other Parent/Guardian's Last Name_____ First _____

Relationship to Patient: □ Mother □ Father □ Other _____

Address □ Same as Above Street: _____ City/State/Zip _____

Home Phone # ( ) _____ Work Phone # ( ) _____ Cell Phone # ( ) _____

Date of Birth ____/_____/_____ Guarantor: □ Yes □ No

MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $_____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

_____ _____/_____/_____

Signature of Patient / Guardian Date

Patient Health History Form

CapitalCare Pediatrics Troy
of Community Care Physicians

Child's Name: _____ **Date of Birth:**_____ **Age:** _____
Today's Date:_____ **Preferred Pharmacy:** _____
Previous Pediatrician (Name and Location): _____

PREGNANCY/DELIVERY:

1. Is this your child by □ Birth □ Adoption □ Foster □ Other _____
2. Birth weight: _____ Birth length: _____ **Type of delivery**: □ Vaginal □ C-section
   Birth hospital: _____
3. Was your baby born full term? □ Yes □ No, premature at _____ weeks
4. Were there any complications of the pregnancy? □ No □ Yes _____
5. Were there any complications of the delivery/newborn period? □ No □ Yes _____
   _____

HEALTH HISTORY:

1. Any history of medical problems?_____
   _____
2. Any surgeries in the past? □ No □ Yes _____
3. Please list all medications your child takes: _____
4. Does your child have any allergies to medications or foods? □ No □ Yes _____
5. Has your child been seen by a dentist? □ Yes □ No When was the last visit? _____

DEVELOPMENTAL HISTORY:

1. At what age did your child:
   - Sit Alone _____ - Walk Alone _____ - Say words _____ - Toilet Train _____
2. Girls: When was your first menstrual period? _____

SOCIAL HISTORY:

Who lives at home with your child [including parent(s)]?

Name	Age	Relationship	Occupation

Are the child's parents:
□ Married □ Unmarried
□ Separated □ Divorced
□ Other

Does anyone smoke at home or outside the home?
□ Yes □ No

Any concerns for lead exposure at home?
□ Yes □ No

Do you feel safe at home?
□ Yes □ No

FAMILY HISTORY:

Is there any family history of the following medical problems (in child's siblings, parents, grandparents, aunts/uncles)? If present, please indicate who.

- □ Heart disease _____
- □ Heart attack _____
- □ Diabetes _____
- □ High Blood Pressure _____
- □ Obesity _____
- □ Stroke _____
- □ Asthma _____
- □ Bleeding Disorders _____
- □ Seizures _____
- □ Genetic Diseases _____
- □ Thyroid Disease _____
- □ Psychiatric Disorders _____
- □ Alcohol/Drug Dependency _____
- □ Other _____

Patient Health History Form

CapitalCare
Pediatrics Troy
of Community Care Physicians

REVIEW OF SYSTEMS:

Has your child had any of the following issues over the past 2 weeks?

Constitutional
- ☐ Fevers, chills, excessive sweating
- ☐ Unexplained weight loss

Eyes
- ☐ Squinting
- ☐ "Lazy eye"
- ☐ Blurry vision
- ☐ Itchy eyes

Ears/Nose Throat
- ☐ Difficulty hearing
- ☐ Mouth breathing/snoring
- ☐ Frequent runny nose
- ☐ Problems with teeth/gums

Respiratory
- ☐ Cough
- ☐ Wheeze

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation
- ☐ Blood in the stool

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Shortness of breath
- ☐ Fainting

Genitourinary
- ☐ Bedwetting
- ☐ Pain on urination
- ☐ Discharge from genitals

Neurologic
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Muscular
- ☐ Muscle/joint pain

Skin
- ☐ Rashes
- ☐ Unusual Moles

Psychiatric/Development
- ☐ Anxiety/depression
- ☐ Issues with sleep
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/jealousy
- ☐ Speech problems

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Vaccine Policy Statement

CapitalCare
Pediatrics Troy
of Community Care Physicians

Patient's Name: _____
Date of Birth: _____

We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that vaccines help to maintain healthy children and communities. As medical professionals, **we feel that vaccinating children following the recommended schedule with currently available vaccines is absolutely the right thing to do for all children and young adults**. We firmly believe that:

- Vaccines prevent serious illness and save lives.
- Vaccines are safe.
- Vaccines DO NOT cause autism or other developmental disabilities.
- Vaccines may be the single most important intervention we perform as healthcare providers.

Our policy at Pediatrics Troy is that:

- We follow the American Academy of Pediatrics (AAP) Immunization Guideline and CDC Immunization Schedule
- **We require all patients to be vaccinated**- barring specific medical exceptions (immunodeficiency, etc.)
- If despite our recommendations, you refuse to vaccinate your child, we ask you to find another healthcare provider who shares your views.

Please recognize that by not vaccinating, you are putting your child and others around you at unnecessary risk for life threatening illness, disability, and even death.

ATTESTATION:

I agree with the vaccine policy of Pediatrics Troy. My child will be vaccinated: □ YES □ No

_____ _____
Parent/Guardian Signature Date

Pediatrics - Troy
258 Hoosick St., Suite 100, Troy, NY 12180
Phone: 518-272-0232 Fax 518-272-4083

CapitalCare
Pediatrics Troy
of Community Care Physicians

Patient Authorization

Who is authorized to bring the child for medical care?

I,_____ (name of custodial parent), give permission for_____ to bring my child/children in for medical care.

What can they consent to?

_____ Vaccine Administration

_____ Medication to be given to my child in office

Can another authorized caregiver verbally communicate with us over the phone? If yes who? Relationship? _____

_____

To whom can we release medical information or health forms?

_____ School

_____ Daycare/Babysitter

_____ Camp/Sport Club

_____ Other

This permission will remain in effect until I withdraw permission in written form.

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

Parental Signature _____ Date _____

COMMUNITY CARE PHYSICIANS

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE CONTACT:

Mackensie Greene, Esq.
Privacy Officer
6 Wellness Way, Suite 201
Latham, NY 12110 (518) 782-3700

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI. The uses are for Treatment, Payment, and Operations (TPO).

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
   Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI 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 for what range of 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 IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI 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 IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. We will not sell your data to an outside entity, nor will we permit an outside entity from accessing your information for purposes of informing you of health-related benefits or services.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you in some limited circumstances. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

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

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI 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.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI 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
   - 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).

5. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI 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.

7. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

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

E. YOUR RIGHTS REGARDING YOUR IIHI

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein and the following rights regarding the IIHI 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 your physician 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 IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **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.

   You also have the right to request a restriction in our use or disclosure of your IIHI to a health plan where the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. In this circumstance, we are required to agree to your request, except where we are required by law to make a disclosure.

   In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to your physician. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI 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 your physician in order to inspect and/or obtain a copy of your IIHI. 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. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend 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. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI 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.** All of our patients 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 IIHI for non- treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your physician. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Mackensie Greene, Esq. at (518) 782-3700.**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Mackensie Greene, Esq. at (518) 782-3700.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **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. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions to include certain treatment, payment, or healthcare operations); use or disclosure of IIHI for marketing purposes; and disclosures that constitute a sale of IIHI.

   Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. **Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured IIHI.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Mackensie Greene, Esq. (518) 782-3700.**

Effective Date of Notice: April 14, 2003
Revised: June 1, 2013

Community Care Physicians

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians,
Print Patient Name

Notice of Privacy Practices.

_____	_____	_____
Signature of Patient or Guardian	Date of Birth	Date

_____	_____
Witness	Date

COMMUNITY CARE PHYSICIANS

GENERAL

PATIENT HIPAA AUTHORIZATION

THIS IS NOT A MEDICAL RECORDS REQUEST FORM. TO REQUEST A COPY OF YOUR RECORDS, PLEASE SEE THE FRONT DESK OR VISIT www.communitycare.com

Patient's Full Name (Last, First) **Patient's Date of Birth**

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **RELEASED or SHARED BY Community Care Physicians** to the following:

Name(s)/Entities (please include address and phone number):_____

_____

_____

Step 2: What Can We Share?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

Please Initial: _____: I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information below. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care out of CCP to a New Provider ☐ Legal Request ☐ Other:_____

Step 3: When Does this Authorization Expire?

This authorization will expire on_____

{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. This authorization may include disclosure of information relating to all Community Care Physicians' offices I have visited. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____ _____

Print Name of Patient or Legal Guardian ***Signature of Patient or Legal Guardian***

Date: _____ ***Relationship to Patient***: _____