HarmonyHealthcare Long Island

Patient Registration Form

Patient Information

Last Name First Name Middle		Home Phone Cell Phone	Primary Contact ❑ Home ❑ Cell ❑ Work
DOB / / SSN#	Country Of Birth	Work Phone	
Mailing Address City State	Apt# Zip	Ok to leave voice message: ❑ Yes ❑ No Ok to leave a text message: ❑ Yes ❑ No *MSG & data rates may apply Best time to reach you: ❑ AM ❑ PM Opt out of all Practice Communication ❑	
Home Address (If Different from Mailing)		Email Address	
City	State / Zip	Preferred Language	Interpreter Needed? ❑ Yes ❑ No

We are requesting the following information of all patients in order to understand our patient needs better, to help our staff use the most respectful language when addressing you, and for funding purposes that may help reduce the cost of your healthcare.

Gender at Birth
❑ Female ❑ Male

Preferred Gender:

Gender Identity - Check as many as apply
- ❑ Male
- ❑ Female
- ❑ Female-to-Male/Transgender
- ❑ Male-to-Female/Transgender
- ❑ Gender queer, neither exclusive male nor female
- ❑ Choose not to disclose

Sexual Orientation - Check one
- ❑ Straight/ Heterosexual
- ❑ Lesbian/Gay/Homosexual
- ❑ Bisexual
- ❑ Do Not Know
- ❑ Choose Not to Disclose
- ❑ Something else, please describe:

Student
- ❑ Full Time
- ❑ Part Time
- ❑ Not a Student

Ethnicity
- ❑ Andalusian
- ❑ Argentinean
- ❑ Asturian
- ❑ Belearic Islander
- ❑ Bolivian
- ❑ Canal Zone
- ❑ Canarian
- ❑ Castillian
- ❑ Catalonian
- ❑ Central American
- ❑ Central American Indian
- ❑ Chicano
- ❑ Chilean
- ❑ Colombian
- ❑ Costa Rican
- ❑ Criollo
- ❑ Cuban
- ❑ Dominican
- ❑ Ecuadorian
- ❑ Gallego
- ❑ Guatemalan
- ❑ Hispanic or Latino
- ❑ Honduran
- ❑ La Raza
- ❑ Latin American
- ❑ Mexican
- ❑ Mexican American
- ❑ Mexican American Indian
- ❑ Mexicano
- ❑ Nicaraguan
- ❑ Not Hispanic or Latino
- ❑ Panamanian
- ❑ Paraguayan
- ❑ Peruvian
- ❑ Puerto Rican
- ❑ Salvadoran
- ❑ South American
- ❑ South American Indian
- ❑ Spaniard
- ❑ Spanish Basque
- ❑ Uruguayan
- ❑ Valencian
- ❑ Venezuelan
- ❑ Declined to Specify

Employment Status
- ❑ Full Time
- ❑ Part Time
- ❑ Migrant
- ❑ Seasonal
- ❑ Retired
- ❑ Active Military
- ❑ Self Employed
- ❑ Not Employed

Employer Name:

Are you a

Veteran	❑ Yes	❑ No
Board Member	❑ Yes	❑ No
HHLI employee	❑ Yes	❑ No

Housing Status
- ❑ Own – Private
- ❑ Rent – Private
- ❑ Rent – Public Housing (Section 8, NYCHA)
- ❑ Senior Housing
- ❑ Homeless Shelter
- ❑ Street
- ❑ Transitional
- ❑ Doubling up

Marital Status
- ❑ Single
- ❑ Widowed
- ❑ Separated
- ❑ Married
- ❑ Divorced
- ❑ Partner

How did you hear about us? (Please check one)
- ❑ Employee
- ❑ Patient/Friend
- ❑ Newspaper
- ❑ Flyer/Poster/Brochure
- ❑ Referral
- ❑ Insurance Company
- ❑ Facebook/Social Media
- ❑ Other:

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Race	❑ American Indian or Alaskan Native	❑ Guamanian or Chamorro	❑ Samoan
	❑ Asian Indian	❑ Japanese	❑ Vietnamese
	❑ Black or African American	❑ Korean	❑ White
	❑ Chinese	❑ Native Hawaiian	❑ Other Race
	❑ Filipino	❑ Other Pacific Islander	❑ Declined to Specify

Emergency Contact

Emergency Contact Full Name	Relationship
Address	Phone Number

Parent/Guardian Information – Please complete if patient is under 18 years of Age				Responsible Party
Mother's Name	DOB / /	Phone	Address	❑
Father's Name	DOB / /	Phone	Address	❑
Guardian's Name	DOB / /	Phone	Address	❑

Insurance Information:

Primary Insurance Name	Policy #
Name of the Insured: ❑ Same as Patient	DOB of Insurance Holder / /
Patient's Relationship to the Insured ❑Self ❑Spouse ❑Child ❑Other:	Primary Care Provider on Insurance Card
Secondary Insurance Name:	Policy #

Pharmacy Information

Pharmacy Name	Phone	Address

Primary Care Provider

PCP Name	Phone	Address
Do you have an Advanced Directive? ❑ Yes ❑ No		**Do you have a Living Will? ❑ Yes ❑ No**

Other Healthcare Providers:

Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty
Name	Phone: Fax:	Specialty

I agree to allow Harmony Healthcare LI to contact me regarding my private health information, evaluation, and treatment.

Signature of Patient or Representative _____ Date _____

I verify that the information above is correct to the best of my knowledge.

Signature of Patient or Representative _____ Date _____

516-296-3742
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Harmony Healthcare LI, Inc. Consent Form

Consent to Treatment: I authorize Harmony Healthcare LI, Inc. (HHLI) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of HHLI's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by HHLI personnel. HIV testing is now a part of routine care and written consent is no longer required. I do have a right to decline HIV testing at any time. The HHLI offers family planning services. I understand that my acceptance of family planning services is not a prerequisite to eligibility for, or receipt of, any other services that is offered by the HHLI.

Release of Information: I authorize HHLI to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable HHLI to obtain payment for the services it provides to me; and (3) to permit HHLI to carry out ordinary health care and business operations such as quality assurance, service planning and general administration. I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic disease

I am aware that Harmony Healthcare LI, Inc. may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits: I assign to HHLI all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by HHLI

Financial Obligations: I agree, that, except as may be limited by law or HHLI's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at HHLI facilities in accordance with the rates and terms of HHLI in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

No- Show Policy – Important Notice:
Please remember to be courteous to us and other patients by calling **at least 4 hours prior** to your appointment time to cancel if you cannot make it. This will allow us to serve our patients better. Patients arriving **more than 15 minutes late** for their appointment will be counted as a no show and they will need to reschedule their appointment. **For dental services**, patients arriving **more than 5 minutes late** for their appointment will be counted as a no show and they will need to reschedule their appointment.

Reports to NYS Immunization Information System: I hereby authorize HHLI to report any immunizations that its medical staff administers to me to the New York State Immunization Information System.

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Signature of Patient or Representative: _____ Date: _____

Nature of Relationship to Patient (if patient not signing): _____

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Healthix - Authorization for Access to Patient Information

Patient Name:	**Date of Birth:**
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 Harmony Healthcare Long Island 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 Harmony Healthcare Long Island to access ALL of my electronic health information through Healthix to provide health care.
☐ 2. **I DENY CONSENT** for Harmony Healthcare Long Island 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)
   - 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 Harmony Healthcare Long Island at 516-296-3742; 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, in case of a minor until he/she turns 18 years of age, or until 50 years after your 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.

HarmonyHealthcare
Long Island

PATIENT ACKNOWLEDGMENT
OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have been provided a copy of the Harmony Healthcare Long Island, Inc. (HHLI) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by HHLI and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient or Representative: _____ Date _____

Name of Personal Representative:_____
(Printed) (If Applicable)

Relationship to Patient: _____
(If Applicable)

← To view our Privacy Notice prior to signing, please scan the QR code. A printed copy can also be provided upon request.

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Patient Code of Conduct

Harmony Healthcare Long Island (HHLI) believes in treating people with respect and courtesy. Our goal is to support them in being healthy. To do this, we need to have a safe space for all patients, clients, families, and staff.

As a patient, I understand that HHLI expects me to:

1. Be respectful and thoughtful of other patients, staff, and any other person in the health center or HHLI property.
2. Be respectful and thoughtful of HHLI property and other people's property.
3. Provide full and correct information about my health. This includes health problems I have now and have had in the past, medicines that I take, times that I have been in the hospital, and any other matter that has to do with my health.
4. Provide the right information about my health insurance or other information that has to do with payment for my care.
5. If you have any questions about the care or our unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
6. Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
7. Questions about your billing from the HHLI can be addressed by contacting the billing department at: 516-296-2700 Option 1, Mailbox #60998
8. Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away. Do not record any part of your visit to the health center without permission of staff and other patients who may be recorded.
9. Adults are expected to supervise their children.

The following behaviors are not acceptable:

- Cursing or swearing
- Using threatening or sexually inappropriate language or behavior
- Intimidating or harassing staff or other patients
- Making threats of violence or harm through phone calls, letters, voicemail, email or other forms of written, verbal, or electronic communication
- Physically assaulting or threatening to inflict bodily harm
- Damaging business equipment or property
- Making menacing or derogatory gestures or remarks
- Making racial or cultural slurs
- Possessing firearms or weapons
- Drinking or drug use at the health center or on HHLI property

- Smoking at or near the health center or HHLI property
- Stealing from the center, center staff, or other patients
- Threatening or inappropriate postings on social media about HHLI or its *staff.*

We expect all patients to follow our Code of Conduct. HHLI will enforce this Code of Conduct. We may ask you not to come to our health center if you do not follow it.

I have received the Patient Code of Conduct. I understand my responsibility to follow the Patient Code of Conduct.

Patient Signature	Print Patient Name	Date
_____	_____	_____
Witness Signature	Print Witness Name	Date
_____	_____	_____

Eligibility Determination for Sliding Fee Discounts

It is Harmony Healthcare Long Island, Inc. (HHLI) policy to provide essential services to all patients regardless of the patient's ability to pay. Discounts are set by the HHLI consumer Board of Directors and are offered based on the information you provide regarding your family size and income. If you are eligible for a sliding fee discount, it will apply to all services received at HHLI, but not for those services provided outside the Health Center.

Please complete the following information, even if you have insurance.

Household Income Before Taxes

HOUSEHOLD MEMBER	NUMBER	Please Fill Out One Income Section Below			
		WEEKLY INCOME	BI-WEEKLY INCOME	MONTHLY INCOME	YEARLY INCOME
Self Name:					
Spouse					
Dependent Children					
Other dependents					
Total					

❑ I am declining to provide information on my income and family size and agree to pay the full HHLI fee.

ACCEPTABLE PROOF OF INCOME IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP HHLI INFORMED.

❑ I certify that all information shown above is true, accurate and correct. I understand that if HHLI determines that misrepresented or falsified information, I will no longer receive discounts and may be asked to pay back discounts

❑ I agree to provide documentation of my income at my next visit.

Name (print)_____ Signature:_____

Witness:_____ Date:_____

Staff to complete information below

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1. Eligible for Sliding Fee Discount: Yes _____ No _____ Patient Refused ____
2. If yes, acceptable proof of income provided: Yes _____ No _____ Patient Refused ____
3. If insured, Health insurance card provided: Yes _____ No _____ Not applicable ____
4. Patient reports no income Yes _____
5. Patient is unable to obtain proof from an employer (This includes paid in cash/off the books earnings) Yes _____

If yes, to either question 4 or 5, please fill out the attached Self-Attestation Form

Family Planning Sliding Scale Code (SS1- SS5 or N/A) _____

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Long Island

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

HIPAA protects the privacy and security of patient medical information in both written and electronic forms and establishes safeguards that health care providers must implement to protect that information. It also regulates what medical information can be transmitted to other providers and health insurers. The Authorization for Release of Health Information form, when signed, allows us to request a copy of your previous medical records from other medical offices, specified individuals, or organizations, according to the details indicated in the form.

Please review the Authorization for Release of Health Information on the next page and complete the appropriate sections.

HarmonyHealthcare
Long Island

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:
	Social Security Number:
Address:	

I, or my authorized representative, request that health information regarding my care and treatment 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 9(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 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health 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. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S) SPECIFIED IN ITEM 9 (b).**

7. Contact information or health care provider or entity to release this information (from who):		
Name:	Address:	
Phone:		
8. Contact information of person(s) or entities who will receive this information (to who):		
Name:	Address:	
Phone:	Fax:	E-mail:

Delivery Details: (**check one**)

☐ Regular mail ☐ Fax (include fax number above) ☐ E-mail (include email above)

☐ Pick up at HHLI Roosevelt
380 Nassau Road Roosevelt NY 11575

☐ Other (please explain): _____
_____

9 (a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records and records sent to you by other health care providers.

☐ Other: _____
_____ _

Include: (*Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to discuss health information	
9 (b). ☐ By initiating here _____ I authorize _____ **(**Name of individual health care provider) to discuss my health information with _____ _____ Relationship to patient: _____	
10. Reason for release of information: ☐ At request of individual ☐ Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of 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.

_____ _____

Signature of Patient or representative authorized by law. Date:

*** 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.**

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

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 off-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 specific 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 findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health;

(13) Privacy and confidentiality 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.

NEW YORK STATE | Department of Health

Patients' Rights, 10 NYCRR, Section 751.9