Greene County Mental Health Center
905 Greene County Office Building
Cairo, New York 12413
518-622-9163 Fax: 518-622-8592

Confidential

For Office Use Only

Account #_____

Intake Person_____

Today's Date: _____

Patient Information Only: *Please Print Clearly*

Last Name: _____ Suffix: ____ First Name: _____ Middle Name: _____

Social Security Number: _____--_____--_____ Date of Birth: _____

Legal Gender at Birth: [ ] Female [ ] Male Gender Identity: [ ] FTM*[ ] MTF* [ ] Non-Binary [ ] Other [ ] No Response

Marital Status (Check): [ ] Single [ ] Married [ ] Life Partner [ ] Divorced [ ] Widowed

Physical Address: _____ City: _____ State: ___ Zip: _____

[ ] *Check if mailing address is same a Physical Address if not please enter below*

Mailing Address: _____ City: _____ State: ___ Zip: _____

Home Phone: (____) _____--_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____ Ext: _____

Preferred Alias Name (Nickname):_____ Email: _____

Sexual Orientation: [ ] Homosexual [ ] Heterosexual [ ] Bisexual [ ] Something Else [ ] No Response

How should we refer to you? Please Select All that Apply: He/Him She/Her They/Them

Race (Check): [ ] American Indian/Alaska Native [ ] Asian [ ] African American [ ] Native Hawaiian/Pacific Islander
[ ] Hispanic [ ] Caucasian/White [ ] Patient Refused

Preferred Language: [ ] English [ ] Spanish [ ] French [ ] Italian [ ] German [ ] Hindu [ ] Hebrew [ ] Other _____

If Student - School District: _____ School Name: _____ Grade: _____

Highest Level of Education: [ ] Grade School [ ] High School [ ] Vocational School [ ] Some College [ ] Associates Degree

[ ] Bachelors Degree [ ] Master's Degree [ ] other _____

Employment Status (Check): [ ] Full-time [ ] Part-Time [ ] Retired [ ] Disabled [ ] Unemployed [ ] Self-Employed [ ] Homemaker

Employer Name: _____

Have you ever previously served or are you currently serving in the Military? [ ] Prior Service [ ] Currently Serving [ ] Veteran

---

Primary Care Physician: Name_____ Phone: _____

Pharmacy: Name_____ Phone: _____

Dentist: Name_____ Phone: _____

If patient is a minor:

[ ] Mother or [ ] Guardian

Name: _____ Address: _____

Home Phone: (___) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (___) ____-_____

[ ] Father or [ ] Guardian

Name: _____ Address: _____

Home Phone: (____) _____-_____ Cell Phone: (___) _____-_____ Work Phone: (___) _____-_____

Members of your Household:

Name	Relationship	Age	Date of Birth

Party Responsible for Insurance. If self, please list your name exactly as it appears on your insurance card.

Insured's First Name: _____ Last Name: _____ MI: _____

Address: _____ Apartment #: _____ City: _____

State: _____ Zip: _____

Primary Phone: (_____) _____--_____

Self-Pay (Y/N) _____ Note** *If (yes) please ask receptionist for self-pay form*

Primary Insurance Company/Medicare: _____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

Secondary Insurance Company:_____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

Tertiary (Third Payer) Insurance Company:_____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

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Director of Community Services

CONSUMER INFORMED CONSENT & SERVICE AGREEMENT

Welcome to Greene County Mental Health Center/Community Services Board. As we begin our work together, there are a few things you should know that will help you best use our services. Please direct any questions about this service agreement to your intake worker.

GCMH/CSB's Responsibility to You:

- We will provide you with mental health treatment for your specific condition. We are licensed to provide individual, group and family outpatient treatment. We will coordinate our treatment with any other providers involved with your care.
- We will inform you if we believe that your need for treatment exceeds our abilities or if we believe that you are not in need of our services. We will also make the appropriate referrals whenever possible and assist you in getting the correct level of care.
- We will supply you with a treatment environment that assists you in your efforts to help yourself. On that order, the clinic's staff will be timely for your appointments, respect your privacy, make reasonable accommodations if you have a disability that makes engaging our service difficult, respect your decision to stop treatment, and provide you with recourse if you have a complaint about our service without fear of reprisal.
- We follow the New York State Office of Mental Health Rights of Outpatients that is posted at every licensed site. It contains your rights as a consumer and whom you can contact if you feel you are not being treated fairly.
- **If you have any after-hours emergencies that cannot wait until the next business day, you can reach our on-call clinician at 518-622-3344.**

Your Responsibility to GCMH/CSB:

- While in treatment you will be expected to participate in planning your treatment and following through. You may be asked to do homework, participate in groups, or sign releases of information, if indicated for your treatment.

  _____
  Client Initials

- While in treatment you will be expected to communicate to your clinician any changes you experience that directly affect your treatment. For example, if you are in treatment for depression and you start to have suicidal thoughts, we expect you to notify your clinician or other staff of that development. Another example would be if you are getting substance abuse treatment and you relapse. Your clinician needs to know so that we can help you.

  _____
  Client Initials

- While in treatment you are expected to pay any fees or make arrangements to have the fees paid by a third party. You will be expected to work with our clinic on questions regarding your insurance or managed-care company.

  _____
  Client Initials

- While in treatment you are expected to cancel appointments 24 hours in advance. Failing to do so is considered a "Missed Appointment." If you fail to cancel 24 hours in advance or miss any appointments without notice, the clinic reserves the right to charge you for such missed appointments. Failure to attend scheduled appointments could result in your termination from the clinic. It is your responsibility to obtain a follow-up appointment from your clinician if you cancel or miss an appointment.

  _____
  Client Initials

GCMH/CSB Limits of Confidentiality:

Greene County Mental Health/Greene County Community Services Board closely adheres to New York State Mental Hygiene Law and to Federal Guidelines regarding confidentiality of mental health, substance abuse, and HIV information. All information about your treatment is confidential as defined by the above laws.

Most disclosures occur only when you sign an authorization form allowing us to release information about you and your treatment. This is the primary method that GCMH/GCCSB uses to release information to anyone, including a family member. Please note that any information that is disclosed will be limited to what you and your clinician decide to be appropriate for the situation. There are, however, the following exceptions to confidentiality that are important to be aware of:

- We are ethically and legally obligated to disclose relevant information in the event of various emergency situations, such as if we believe that you or another person in the community may be at risk of serious harm. At those times we are obligated to inform authorities and/or the person targeted for harm. There are also other emergency situations in which the Mental Health Association of Columbia & Greene Counties' Mobile Crisis Assessment Team (MCAT) may be notified to intervene in an emergency situation in order to ensure your well being.

- We are not permitted to contact family members in the event of an emergency. You, however, can authorize Greene County Mental Health Center to do so by filling out the attached emergency form. We will only use this in the event of an emergency.

- We are allowed, and at times required, to disclose information under various legal compulsions such as: when child abuse or neglect is suspected or has occurred, when New York State Mental Hygiene Legal Services request information, to attorneys challenging involuntary hospitalization, to the NYS Justice Center or its representatives, to NYS Board for Professional Medical Conduct, to the local director of mental hygiene, or when we receive an authorizing court order from a judge. All of these situations tend to be very rare.

- Protected Health Information (PHI) will be sent to the Regional Health Information Organization operated by HIXNY, which is part of a statewide computer network; however, your consent is needed in writing in order for *any other* medical providers to retrieve any of your medical information.

- We are allowed to disclose information if a crime has been committed on the premises or against clinic personnel. We will only disclose to the authorities the minimal amount of information necessary for law enforcement to conduct their duties.

- We are allowed to disclose information with other providers who are involved or are planning to be involved in your care. This may include your primary care physician or other agencies, such as Twin County Recovery Services, Mental Health Association (MHA) of Columbia and Greene Counties, MHA's Mobile Crisis Team, and Columbia Memorial Hospital. While we have the right to disclose certain pertinent information to coordinate care and/or an emergency response, whenever possible we will ask for your permission to do so prior to any release of information.

- We will not re-disclose any information that we receive from other treatment providers.

Please know that regardless of the circumstances, it is always our ethical and legal obligation to disclose only the minimal amount of information relevant to the particular situation. It is also our ethical obligation to discuss with you any information that is shared with other professionals, except in emergencies where we are unable to do so.

_____

Client Initials

GREENE COUNTY MENTAL HEALTH CENTER/COMMUNITY SERVICES BOARD
CONSUMER INFORMED CONSENT & SERVICE AGREEMENT

Thank you for reading the Greene County Mental Health Center/Community Services Board Consumer Informed Consent and Service Agreement. Please direct any questions about this agreement to your clinician.

Please complete the form below confirming you have read the agreement, understand its contents, and agree to its terms.

Client Name: _____ **Account #**:_____

Name of Emergency Contact: _____

Relationship to contact: _____

Address of contact: _____

Home Phone: _____

Work Phone: _____

☐ ***My Emergency Contact has permission to change, cancel, reschedule, or confirm appointments on my behalf.***

Special Instructions:

_____

_____

_____

Greene County Mental Health Center utilizes an automated telephone service that notifies you of your future appointments. If you would like to opt out of this appointment reminder system please check the box below otherwise select your preferred reminder option.

☐ ***I do not wish to have automated reminder calls about my upcoming appointments.***

☐ **Call me**: I _____ authorize Greene County Mental Health center to confirm my upcoming appointments to phone number: (_____) _____-_____.

☐ **Text me:** I _____ authorize Greene County Mental Health center to confirm my upcoming appointments by texting phone number: (_____) _____-_____.

I recognize that normal text messaging rates may apply.

☐ **Email me:** I _____ authorize Greene County Mental Health center to confirm my upcoming appointments to my email address: _____

By signing below I acknowledge that I have read this agreement, understand its contents, and agree to its terms.

_____ **Date**: _____

Patient Signature or
Legal Guardian (if client is under 18 years of age)

Revised: 1/7/2019

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Director of Community Services

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

AUTHORIZATION FOR RELEASE OF INFORMATION BY THE GREENE COUNTY MENTAL HEALTH CENTER/GREENE COUNTY COMMUNITY SERVICES BOARD: I hereby authorize and direct the Greene County Mental Health Center/Greene County Community Services Board, having treated me, to release to government agencies, insurance carriers, or others who might be financially liable for my medical care, all information needed to substantiate payment for such medical care.

ASSIGNMENT OF BENEFITS TO THE GREENE COUNTY MENTAL HEALTH CENTER/GREENE COUNTY COMMUNITY SERVICES BOARD: I hereby assign and set forth to the Greene County Mental Health Center/Greene County Community Services Board, sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent by the Center.

_____ _____

WITNESS

SIGNATURE OF PERSON TREATED OR AUTHORIZED REPRESENTATIVE

FOR CLIENTS WHO ARE ENTITLED TO MEDICARE BENEFITS

MEDICARE ASSIGNMENT: I hereby certify that the information given in applying for payment under the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

_____ _____

WITNESS

SIGNATURE OF PERSON TREATED OR AUTHORIZED REPRESENTATIVE

Greene County Mental Health Center
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PATIENT BILL OF RIGHTS

YOU HAVE THE RIGHT:

- To quality care and treatment
- To be treated with dignity & respect
- To know about and help plan all aspects of your care, treatment and recovery program
- To object to any part of your care and treatment which you do not feel is helping you (except when there is risk of harm to yourself or others)
- To appeal any decisions about your program and to have those decisions reviewed by a higher authority
- To have all medical records and files kept private
- To have an individual program based on your changing needs
- To review treatment records and receive a copy of the records
- To participate voluntarily in and consent to treatment
- To have access to the advocacy groups listed below:

NYS Commission on Quality of Care for the Mentally Disabled
401 State Street, Schenectady, NY 12305
518-388-2888

NYS Office of Mental Health
44 Holland Avenue, Albany, NY 12229
800-597-8481

National Alliance for the Mentally Ill of NYS
260 Washington Avenue, Albany, NY 12210
518-462-2000

Protection & Advocacy for Individuals Who Are Mentally Ill
PAIMI of Hudson Valley Region
155 Washington Ave., Suite 300, Albany, NY 12210
518-432-7861

_____
Client Initials

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PERMISSION TO TREAT A MINOR

I, _____, give permission
Parent/Guardian

for _____ to receive
Name of Minor

mental health services from Greene County Mental Health Center/Community Services Board.

I understand that proper treatment of my child's psychiatric condition may require medication.

_____ _____
(Signature if of Parent/Guardian) Date

_____ _____
(Signature of Therapist) Date

POLICY ON FAMILY INVOLVEMENT and MISSED APPOINTMENTS

Family Involvement

- Family involvement is a mandatory part of your child's treatment.
- You must make a commitment to face-to-face contact and/or telephone communication with the therapist to keep your child's case open. Your child's therapist will discuss this with you during the assessment process.
- Family involvement is important because:
    - It provides feedback on your child's behavior and mood at home.
    - It assists the therapist in determining if there are ways your family can help your child meet his/her goals in therapy.
- At least one parent/legal guardian must accompany the child to medication management appointments.

Making Your Appointments

- Therapy is most successful when patients attend their sessions regularly.
- If your scheduled appointment must be canceled, please do so 48 hours prior to the appointment time.
- If you fail to make your appointment or cancel on the same day of the scheduled appointment, this will be considered a "no-show/missed appointment."
- After two or more "no-show/missed appointments" for therapy or medication, your case may be closed.
- When your case is closed, all clinic-related services are terminated, including both verbal therapy and medication management.

Please indicate that you have read and agree to this policy.

_____

Parent/Legal Guardian's Signature Date

_____

Therapist's Signature Date

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I DENY CONSENT"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

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

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I GIVE CONSENT for this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I DENY CONSENT for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

If you choose to "Deny Consent" on that form, GCMH ***will not*** refuse treatment to you.

_____	_____	_____
Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
_____	_____	
Signature of Patient or Patient's Legal Representative	Date	
_____	_____	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
_____	_____	
Signature of Witness	Print Name of Witness	

For Office Use: Patient Account #_____ ☐ Entered QDPM ☐ Entered PSYCKES

Revised: 1/7/2019

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health information can only be used by your treatment provider to: • Provide you with medical treatment, care coordination, and related services • Evaluate and improve the quality of medical care provided to all patients • Notify your treatment providers if you have an emergency (e.g., go to an emergency room)
2. **What Types of Information About You Are Included?** If you give consent, Greene County Community Services Board (GCCSB) can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES may include information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. Care plans, safety plans, and psychiatric advanced directives you and your treatment provider may have developed may also be included. This information may relate to sensitive health conditions, including but not limited to: • Mental health conditions • Genetic (inherited) diseases or tests • Alcohol or drug use problems • HIV/AIDS • Birth control and abortion (family planning) • Sexually transmitted diseases
3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be entered by you or your treatment provider. Health information from other databases maintained by NYS is also included in PSYCKES. New health databases may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.
4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: Greene County Community Services Board 's doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for Greene County Community Services Board and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.
5. **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 Greene County Community Services Board at (518)622-9163 or call the NYS Office of Mental Health Customer Relations at 800-597-8481.
6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Greene County Community Services Board; to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.
7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any services from Greene County Community Services Board or until the day you withdraw your consent, whichever comes first.
8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Greene County Community Services Board. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling Greene County Community Services Board at (518)622-9163. Note: Organizations that access your health information through Greene County Community Services Board while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.
9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

Hixny

Hixny Electronic Data Access Consent Form
Greene County Mental Health

In this Consent Form, you can choose whether to allow Greene County Mental Health to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Greene County Mental Health to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Greene County Mental Health's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Greene County Mental Health may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

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

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

_____ _____ _____

Print Name of Patient | Date of Birth | Date

_____ _____

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

_____

Relationship of Legal Representative to Patient (if applicable)

For Office Use: Patient Account #_____

☐ **Entered QDPM** ☐ **Entered EHR** ☐ **Entered HIXNY**

hixny.org

How Your Information Will Be Used

Your electronic health information will be used by Greene County Mental Health only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Greene County Mental Health may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

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

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Greene County Mental Health's medical staff who are involved in your medical care; health care providers who are covering or on call for Greene County Mental Health's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Greene County Mental Health at: (518) 622-9163; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

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

Effective Period

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

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Greene County Mental Health. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

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

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Commitment to You: We at the Greene County Mental Health/Community Services Board (GCMH & GCCSB) understand that the information we collect about you and your health is personal. Keeping your health information confidential and secure is one of our most important responsibilities.

We keep a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information and to following all state and federal laws regarding the protection of your health information.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information," is information about you that may identify you and that relates to your past, present or future physical or mental health condition or care.

We are required by law to:

- ♦ make sure that health information that identifies you is kept private
- ♦ give you this notice of our legal duties and privacy practices with respect to health information about you
- ♦ follow the terms of the notice that is currently in effect.

If you have any questions about this notice, please contact **(518)622-9163.**

2. Who will follow this notice: This notice describes the practices of **Greene County Mental Health/Community Services Board** and that of:

- ♦ Any other facility or program directly operated by GCMH & GCCSB
- ♦ Any student of member of a volunteer group we allow to help you while you are in our care
- ♦ All employees, staff, and other personnel of GCMH & GCCSB
- ♦ Contractors, agencies, or other organizations that provide services to us or on our behalf and who have agreed, in writing, to protect your information and follow this Notice.

3. Your Health Information Rights: You have the following rights regarding the health information we have about you:

♦ **RIGHT to Inspect and Obtain Copies:** You have the right to inspect and obtain a copy of health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

To inspect or obtain a copy of health information that may be used to make decisions about you, you must submit your request in writing to **GCMHC Medical Records, 905 Greene County Office Building, Cairo, NY 12413.**

We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. A Medical Records Access Review Committee will review your request and the denial. The person(s) conducting the review will not include the person who denied your request. We will comply with the outcome of the review.

♦ **RIGHT to Amend:** If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend that information. We may deny your request if you ask to amend information that: (1) was not created by us; (2) is not part of the health information kept by us; (3) is not part of the information which you would be permitted to inspect or copy; or (4) is determined to be accurate and complete. You have the right to request an amendment for as long as the information is kept by or for us.

To request an amendment, your request must be made in writing and submitted to **GCMHC Medical Records, 905 Greene County Office Building, Cairo, NY 12413.** In addition, you must provide a reason that supports your request.

♦ **RIGHT to an Accounting of Disclosures:** You have the right to request a list of information releases that we have made of your health information The list will not include: health information releases that were made: (1) for purposes of providing treatment to you, obtaining payment for services, or releases made for other administrative or operational purposes; (2) for national security purposes; (3) to correctional and other law enforcement custodial situations; (4) based on your written authorization (5) to persons who are involved in your care; or (6) before April 14, 2003.

To request this list or accounting of disclosures, you must submit your request in writing **GCMHC Medical Records, 905 Greene County Office Building, Cairo, NY 12413.** Your request must state a time period, which may not be longer than 6 years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

♦ **RIGHT to Request Restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that we restrict or limit

health information about you that we may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. For example, you could ask that we not use or disclose information about the medication you are taking to your spouse or significant other.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. There is one exception to this: if you have paid for your treatment in full or out of pocket, and request a restriction on disclosures for payment or health care operations purposes to your health plan, we *must* agree to your request. To request restrictions, you must make your request in writing to **GCMHC Medical Records, 905 Greene County Office Building, Cairo, NY 12413.** In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

♦ **RIGHT to Request Confidential Communications**: You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain phone number or by mail.

To request confidential communications, you must make your request in writing to **GCMHC Medical Records, 905 Greene County Office Building, Cairo, NY 12413.** We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

♦ **RIGHT to Notice of Breach:** If there is a breach of your unsecured protected health information (which generally means your health information is not encrypted or otherwise can be read by anyone who looks at it), we must notify you that this has occurred.

♦ **RIGHT to a Paper Copy of this Notice:** You have a right to a paper copy of this notice, which you may request at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, https://www.greenegovernment.com/departments/mental-health. To obtain a paper copy of this notice, contact (518)622-9163.

4 How we may use and disclose health information about you:

Your health information, which includes any information that relates to your past, present, or future health/mental health condition (which might include your photograph), may be used and released by GCMH & GCCSB for the purposes of providing treatment to you, obtaining payment for services, for administrative and operational purposes, and to evaluate the quality of the services you receive. GCMH & GCCSB provides a wide range and variety of health care to the people of Greene County. For this reason, not all types of uses and releases can possibly be described in this document. We have listed some common examples of permitted uses and disclosures below:

♦ **For Treatment:** Caregivers, such as nurses, doctors, therapists and social workers, may use your health information to determine your plan of care. Individuals and programs within GCMH & GCCSB may share health information about you to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or transfers or referrals for follow-up care. We may use health information about you to provide you with treatment or services.

♦ **For Payment:** GCMH & GCCSB may release information about you to your health plan or health insurance carrier to obtain payment for our services. For example, we may need to give your health plan information about a clinical exam or medications that you received so your health plan will pay us for treatment or services we provided. We may also share your information, when appropriate, with other government programs such as Workers' Compensation, Medicaid, Medicare, or Managed Care Organizations to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. We may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but we will only do so as permitted under law. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. If you are due a refund of money because you have overpaid for our services, we may share a limited amount of your information with the NYS Office of the State Comptroller to obtain that refund for you.

♦ **For Operations:** GCMH & GCCSB may use and release information about you to ensure that the services and benefits provided to you are appropriate and are high quality. For example, we may use your information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine health information about many individuals to research health trends, or determine what services and programs should be offered, or whether new treatments or services are useful. We may share your health information with our business partners who perform functions on our behalf. For example, our business partners may use your information to perform coordination of care or other assessment activities. GCMH & GCCSB requires that our business partners abide by the same level of confidentiality and security as GCMH & GCCSB when handling your information.

♦ **To Keep You Informed:** Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health related benefits or services that may be of interest to you or to give you information about your health care choices.

♦ **Facility Directories:** Some GCMH & GCCSB facilities use patient directories. If you are receiving care from a facility that does use one, and if you do not object, we may put your name and location in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.

♦ **To Other Government Agencies Providing Benefits or Services:** We may release your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.
♦ **Research:** GCMH & GCCSB may release your health information for research projects that have been reviewed and approved by a special approval process to ensure the continued privacy and protection of the health information. We may also disclose health information about you to people preparing to conduct a research project, such as to help them look for patients with specific medical needs, so long as the health information they review does not leave our facility.
♦ **As Required by Law:** We will disclose health information about you when required to do so by federal, state, or local law.
♦ **To Avert a Serious Threat to Health or Safety:** We may release your health information if it is necessary to prevent a serious threat to your health or safety or to the health and safety of the public or another person.
♦ **For Public Health Activities:** We may disclose health information about you to public health agencies, subject to the provision of applicable state and federal law, for the following kinds of activities:

- ♦ to prevent or control disease, injury or disability
- ♦ to report births and deaths
- ♦ to report child abuse or neglect to agencies authorized by law to receive these reports.
- ♦ to report reactions to medications or problems with products to the Food and Drug Administration (FDA)
- ♦ to notify people of recalls of products they may be using
- ♦ to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading the disease or condition
- ♦ to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; we will only make this disclosure if you agree or when required or authorized by law

♦ **For Health Oversight Activities:** GCMH & GCCSB may share your health information within GCMH & GCCSB and with other agencies for oversight activities authorized by law. Examples of these oversight activities include audits, inspections, investigations and licensure.
♦ **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may release health information about you in response to a court or administrative order. We may also release health information about you in response to a court order, subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information required.
♦ **For Law Enforcement:** We may release health information to a law enforcement official:

- ♦ in response to a court order, subpoena, warrant, summons, or other similar process
- ♦ to identify or locate a suspect, fugitive, material witness, or missing person
- ♦ about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- ♦ about a death we believe may be the result of criminal conduct
- ♦ about criminal conduct at the hospital
- ♦ in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

♦ **Coroners, Medical Examiners and Funeral Directors:** We may release health information to a coroner or medical examiner to carry out their duties as authorized by law (for example, to identify a deceased person or determine the cause of death). We may also release health information to funeral directors as necessary to carry out their duties.
♦ **Organ Donation:** If you are an organ donor, we may release your health information to an organization that procures, banks, or transports organs for the purpose of an organ, eye, or tissue donation or transplantation.
♦ **National Security and Protection of the President:** We may release your health information to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.
♦ **Inmates/Forensic Patients:** If you are an inmate of a correctional institution, or a person who is receiving care in a psychiatric hospital as a result of a criminal court order or are under custody of a law enforcement official (that is, a forensic patient), we may release health information about you to the correctional institution or law enforcement official. The information released must be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution or psychiatric hospital.
♦ **To the Military:** If you are a veteran or a current member of the armed forces, we may release your health information as required by military command or Veterans Administration authorities.

If you do not object and the situation is not an emergency and disclosure is not otherwise prohibited by stricter laws, we are permitted to release your health information under the following circumstances:

♦ **To Individuals Involved in Your Care:** We may release your health information to a family member, other relative, friend, or other person who you have identified to be involved in your health care or the payment of your health care.
♦ **To Family:** We may use your health information to notify a family member, a personal representative or a person responsible for your care, of you location, general condition, or death.
♦ **To Disaster Relief Agencies:** We may release your health information to an agency authorized by law to assist in disaster relief efforts.

5. What is NOT Covered Under this Notice?

♦ **Confidential HIV Related Information:** Under New York State Law, confidential HIV-related information (information concerning whether or not you have had an HIV-related test, or have HIV infection, HIV-related illness, or AIDS, or which could indicate that a person has been potentially exposed to HIV), cannot be disclosed except to those people you authorize in writing to have it.

♦ **Alcohol or Substance Abuse Treatment Information:** If you have received alcohol or substance abuse treatment from an alcohol/substance abuse program that receives funds from the United States government, federal regulations may protect your treatment records from disclosure without your written authorization.

6. The Office of Mental Health's Requirements: GCMH & GCCSB is required by state and federal law to maintain the privacy of your health information. We are required to give you this notice of our legal duties and privacy practices with respect to the health information that GCMH & GCCSB collects and maintains about you. We are required to follow the terms of this notice.

This notice describes and gives some examples of the permitted ways that your health information may be used or released. Release of your information outside of the boundaries of GCMH & GCCSB related treatment, payment, or operations, or as otherwise permitted by state or federal law, will be made only with your written authorization. You may revoke specific authorizations to release your health information, in writing, at any time. If you revoke an authorization, we will no longer release your health information to the authorized person, except to the extent that we have already used or released that information in reliance on your original authorization.

You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided to you. Greene County Mental Health/Community Services Board does not use your health information for marketing or fundraising purposes, nor will we ever sell your health information.

We reserve the right to revise this notice. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we create or receive in the future. We will post a copy of the current notice in the facility and will provide a copy of our revised notice to you upon request. In addition, each time you are admitted to the facility for treatment as an inpatient or outpatient, we will offer you a copy of the current notice in effect. The notice will contain on the first page, in the top right-hand corner, the effective date.

7. For More Information or to Report a Problem: If you believe your privacy rights have been violated, you may file a complaint with any or all of the agencies listed below. There will be no penalty or retaliation for filing a complaint:

Greene County Attorney's Office **411 Main Street** **Suite 443** **Catskill, NY 12414** Phone: (518)719-3540 Fax: (518)719-3790
Office for Civil Rights: Phone: 866-OCR-PRIV (866-627-7748) 886-788-4989 TTY 877-521-2172 TDD
Secretary of Health and Human Services: 200 Independence Avenue, SW Washington, D.C. 20201 Toll Free Phone: 1-877-696-6775 www.hhs.gov/ocr/hipaa

To obtain more information about GCMH & GCCSB's privacy practices, to receive additional copies of this notice, or to receive request forms to access or amend your health information, please contact:

Phone: (518)622-9163
Fax: (518)622-8592

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Name: _____ **Account #** _____

Facility: Greene County Mental Health/Community Services Board

I have received a copy of the GCMH & GCCSB Notice of Privacy Practices (Effective Date 6/25/2018)

Signature: _____ **Date:** _____

Individual or Personal Representative with legal authority to make healthcare decisions

If signed by a Personal Representative:

Print Name: _____ Role: _____ (Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the personal representative.

If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices given to the individual on _____ **by**
☐ Face to face meeting
☐ Mailing
☐ Other _____

Reason Individual or Personal Representative did not sign this form:
☐ Individual or Personal Representative chose not to sign.
☐ Individual or Personal Representative did not respond after more than **one** attempt.
☐ Other _____

Good Faith Efforts: the following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

☐ Face to face presentation(s) _____
☐ Telephone contact(s) _____
☐ Mailing(s) _____
☐ Other _____

Staff Signature: _____ **Title:** _____

Print Name: _____ **Date:** _____

This form must be retained for a period of at least six years in the appropriate record in accordance with the GCMH & GCCSB Privacy Policy Manual.

Revised: 1/7/2019

Date:_____

Print Patient Name:_____

Consent for Telemental Health Treatment at Greene County Mental Health

AUTHORIZATION FOR RELEASE OF INFORMATION BY THE GREENE COUNTY MENTAL HEALTH CENTER/GREENE COUNTY COMMUNITY SERVICES BOARD:

I hereby authorize and direct the Greene County Mental Health Center/Greene County Community Services Board, to provide treatment via telephonic or video conferencing, to release to government agencies, insurance carriers, or others who might be financially liable for my medical care, all information needed to substantiate payment for such medical care. Patient may withdraw this consent at any time and will not impact the patient ability to receive care by Greene County Mental Health however treatment providers may be changed if the client decides to opt out of Telemental Treatment.

☐ **Patient Consents to Treatment via telephonic or video conferencing.**

☐ **Patient Denies to Treatment via telephonic or video conferencing**

Parent/Guardian Signature

X_____

GREENE COUNTY MENTAL HEALTH CENTER

905 Greene County Office Building

Cairo, NY 12413-2868

Phone: 518-622-9163 Fax: 518-621-4228

Disclosure Statement, Services Agreement,

Privacy Notice, and Consent Form

FOR

(Patient signing for self)

Print Patient Name: _____

I have received and read the Disclosure Statement, Services Agreement, and Privacy Notice from GREENE COUNTY MENTAL HEALTH CENTER.

I agree to participate in assessment and treatment services while abiding by the terms and conditions described in the Services Agreement and Privacy Notice.

I understand that I can revoke this Agreement in writing at any time.

ADDITIONAL CONFIDENTIALITY AGREEMENT FOR ADOLESCENT PATIENTS:

In the interest of promoting privacy and efficacy for my child in psychotherapy, I consent to waive my rights to access to my child's Clinical Record, except for summary information. I have discussed this with my child's clinician and agree to treatment in accordance with the policy described in the Minors and Parents section of the Services Agreement.

Signature of Parent/Guardian: _____

Signature of Patient: _____

(14 years and older)

Date: _____