Concorde Medical Group PLLC

Patient Registration form

(Please Print)

Patient Accnt. # _____ PCP Copay _____SPC Copay_____

Patient information:

Primary Care Provider: _____ Today's Date: _____

First Name _____ Last Name _____ MI _____

Address_____ Apt # _____

City _____ State _____ Zip _____+_____

Home Phone (____) _____ Gender _____ Marital Status _____

Birthdate ____/_____/_____ *E-Mail* _____@_____

Social Security Number _____-_____-_____Cell Phone (_____)-_____-_____ Fax (_____)-_____-_____

WHICH CATEGORY BEST DESCRIBES YOUR RACE? You may select up to two race values:

☐ American Indian or Alaskan Native ☐ Asian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Patient Declined ☐ State Prohibited

ETHNICITY – DO YOU CONSIDER YOURSELF HISPANIC/LATINO?: Yes No

PREFERRED LANGUAGE: _____

Who Referred You? ☐ Physician: _____ ☐ Insurance ☐ Internet ☐ Relative/Friend
☐ Patient ☐ Zoc Doc ☐ JP Morgan ☐ CMG Referral Line ☐ NYU Referral ☐ Clinical Trials ☐ Postcard

Patient Employment Information

Company Name _____

Address _____City _____ State _____ Zip_____+_____

Phone (_____)-_____-_____ Occupation _____

Pharmacy Information

Pharmacy Name _____

Address _____City _____ State _____ Zip_____+_____

Phone (_____)-_____-_____ Fax (_____)-_____-_____

Send Bill to

(If other than self)

First Name _____Last Name _____Relationship to Patient_____

Address _____ Apt._____

City _____ State _____ Zip _____+ _____

Home Phone Number (_____)_____-_____ Social Security Number _____-_____-_____

Policy Holders Date of Birth _____/_____/_____ Gender _____ Marital Status _____

Daytime Number (_____)-_____-_____ Ext _____ Cell # (_____)-_____-_____

Emergency Contact Information:

First Name _____ Last Name _____ MI _____

Address_____ Apt # _____ City _____ State _____Zip _____

Daytime Number (_____)-_____-_____ Ext _____ Home Number (_____)-_____-_____

Cell # (_____)-_____-_____ Relationship to Patient _____

Patient Name_____ Patient Acct #:_____

Primary Insurance Carrier

Insurance Name: _____ ID Number _____

Group Number #_____ Effective Date _____/_____/_____

Claims Address _____ City _____ St. _____ Zip _____ + _____

Policy Holder- Subscriber Information

Patient Relationship to Insured/Responsible Party: Self Spouse Child Other

First Name _____ Last Name _____MI _____

Address _____ City _____ St. _____ Zip _____+_____

Home Phone (_____)-_____-_____ Birth Date ____/_____/_____ Gender _____

Social Security Number _____-_____-_____ Employer _____

DO YOU HAVE SECONDARY INSURANCE*?: Yes No *IF YES, COMPLETE THIS SECTION

Secondary Carrier

Insurance Name: _____ ID Number _____

Group Number # _____ Effective Date_____/_____/_____

Claims Address _____ City _____ St. _____ Zip _____ + _____

Policy Holder – Subscribe Information

Patient Relationship to Insured/Responsible Party: Self Spouse Child Other

First Name _____ Last Name _____MI _____

Address _____ City _____ St. _____ Zip _____+_____

Home Phone (_____)-_____-_____ Birth Date ____/_____/_____ Gender _____

Social Security Number _____-_____-_____ Employer _____

Insurance Assignment and Release

I, the undersigned certify, that I have insurance coverage with _____ and assign directly to Concorde Medical Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered. I hereby authorize the doctor all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible party Relationship Date

Medicare Authorization

I request payment of authorized Medicare benefits be made either to me or on my behalf to Concorde Medical Group for any services furnished me by CMG,I authorized any holder of medical information about me to release to the Centers For Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If “other Health Insurance” is indicated in item 9 of the CMS 1500 form. or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown, in Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non covered services, co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

Concorde
Medical Group PLLC

FINANCIAL POLICY

We are pleased that you have entrusted our physicians with your health care. In doing so, you can be assured that we are committed to providing you with the best medical care possible. We also appreciate that healthcare coverage can be a complex world and recognize the need to establish a clear and concise financial policy that helps you understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions relating to your insurance.

As a policyholder of healthcare insurance, it is your responsibility to be an informed consumer. It is expected that you have an understanding of your policy coverage, including your financial responsibilities – co-payment amounts, any applicable deductibles and coinsurances for both participating and non-participating physicians and facilities; if your plan requires a referral and if precertification is necessary for certain procedures.

PAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT. A VALID CREDIT CARD MUST BE MAINTAINED ON FILE.

We now offer the following payment options:

___Payment by Cash

___Payment by Check

___Payment by Credit Card (Visa or MasterCard preferred)

Payment Policy Schedule*:

Co-payments	Full payment is due at the time of service. Failure to make payment will result in an additional $20.00 statement charge
Deductible and coinsurance	Full payment is due at the time of service
Non-covered service	Full payment is due at the time of service
Non-participating insurance plan	Full payment is due at the time of service

Other charges/fees*:

Missed Appointment Fee	The office requires at least 1 business days notice when cancelling an appointment. Failure to provide this notice will result in a charge of up to $75.00.
Cancellation of GI procedure	The office requires at least 2 business days notice. Failure to provide this will result in a charge of $50.00

Cancellation of Cardiac Testing	The office requires at least 1 business days notice. Failure to provide this will result in a charge of $200
Return Check Fee	A fee of $25.00 will be applied for any check returned
Medical Records	A fee of $0.75 per page due prior to the release of records
Form Fee	Some locations charge $35.00 for processing forms. Please check with your individual physician's office.
Collection fee*	In the event your account is sent to a collection agency, a charge of 35% will be added to your balance. If a payment for services rendered is received by the patient/guarantor/dependent from the insurance carrier and not turned over to CMG within 10 days of receipt, you will be charged 10% interest on the billed amount.

* Subject to change at any time

We understand that medical care can often become very expensive and that temporary financial problems may affect your ability to pay on a timely basis. If such a situation should arise, we encourage you to contact us promptly for assistance. For further information about this or our financial policy, please do not hesitate to contact us at 212-614-0039, Monday through Friday between the hours of 9AM – 4PM.

I fully understand and acknowledge receiving a copy of Concorde Medical Group's Financial Policy. Please sign your name below:

_____	_____	_____
Patient's Signature	Print Name	Dated

Concorde
Medical Group PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on **September 23, 2013** and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, **Lorie Postell**

Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $_____for each page and the staff time charged will be $_____per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Concorde Medical Group, PLLC**

Privacy Officer: **Lorie Postell**

Telephone: **212-614-0039 ext 209**

Fax: **212-253-9631**

Email: **lpostell@concordemed.com**

Address: **316 East 30th Street, 2nd Floor, New York, NY 10016**

Concorde
Medical Group PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

Concorde Medical Group PLLC

***Patient MRN/Patient ID in EMR:

_____

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

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.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

_____ _____
PRINT Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)

Please Fax signed consents to: **917-829-2096**

NYULMC HIE, Care Everywhere and Healthix
Fact Sheet

Details about patient information in the NYULMC HIE, Care Everywhere and Healthix and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the HIE Participants and Care Everywhere Providers 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 provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYULMC healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare 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.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYULMC patients and members.

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.

2. **What Types of Information About You Are Included**. If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the NYULMC HIE and all employees, agents and members of the medical staff of NYU Hospitals Center may access ALL of your electronic health information available through Healthix. 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	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

3. **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 HIE Information Sources is available from NYU Hospitals Center or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the NYULMC HIE website **http://health-connect.med.nyu.edu/. You can contact the NYULMC HIE Privacy Officer by writing to: NYU Langone Medical Center, Privacy Officer, One Park Ave, 10th Floor, New York, NY 10016 or calling: 212-263-8488. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.**

4. **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 the medical staff of an approved HIE Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider's doctors; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE Participant or Care Everywhere Provider 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 one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the NYULMC HIE website: http://health-connect.med.nyu.edu/ or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access

to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix's website: http://www/healthix.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider 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. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the NYULMC HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The NYULMC HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the NYULMC HIE ceases operation, or until 50 years after your death, whichever is later.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to NYU Hospitals Center or one of the other HIE Participants, as applicable. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the NYULMC HIE website http://health-connect.med.nyu.edu/. Once completed please fax to 917-829-2085 or submit to your provider.

   Note: Organizations, including Care Everywhere Providers, that access your health information through the NYULMC HIE and/or Healthix 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. **Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.

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

11. **Risks of Denying Consent**. If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the NYULMC HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.

Concorde
Medical Group PLLC

Authorization to disclose Health Information

Date: _____

Patient Name: _____

I Authorize Dr. _____ to discuss my health information with the following personal representative(s):

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient Signature

It is Concorde Medical Group PLLC Policy to confirm the appointments via telephone or in some cases with an automated appointment confirmation service. I authorize Concorde Medical Group to call me at the following telephone number(s) to confirm my appointment(s):

_____
Home

_____
Work

_____
Cell

I authorize Concorde Medical Group PLLC to send me Patient Satisfaction eSurveys, Newsletters and Bulletins via e-mail in lieu of paper whenever possible.

☐ Check here if you do not have an email address

Email Address:_____

_____
Patient Signature