Harmony Healthcare Long Island at Westbury High School
A Joint Program of the Westbury Union Free School District and HHLI

Westbury High School
1 Post Road
Westbury, New York 11568
Phone: 516-874-1970
Fax: 516-874-1971

It's fast and easy for your child to receive health care services through Harmony Healthcare Long Island (HHLI) at Westbury High School!

Dear Parent or Guardian:

We are happy to inform you that the Westbury High School has a School-Based Health Center (SBHC) run by Harmony Healthcare Long Island. HHLI at Westbury High School is staffed by Harmony Healthcare medical and behavioral licensed health professionals.

Please rest assured that your child can use HHLI at Westbury High School services, much like an Urgent Care Center and continue to see your primary care doctor as you have always done. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see thier primary doctor.

At HHLI at Westbury High School, your child can receive the services listed below at **no cost** to you, regardless of insurance status. HHLI at Westbury High School is allowed to bill insurance, however there are **no co-pays to you**, and **you will not receive a bill.**

HHLI at Westbury High School Services include:

- Complete physical examinations
- Medical laboratory testing
- Immunization review and updating
- Medical care, including treatment for acute and chronic conditions such as, but not limited to, asthma and obesity
- Health Education and Counseling
- Mental Health Counseling and services
- Vision and hearing screening
- Prescription management
- Referrals to specialists
- Access to care Monday - Friday during school hours

To register your child for HHLI at Westbury High School services, please read and complete the following information on the attached enrollment form. Be sure to sign the Parental Consent form.

- **Parental Consent Form**
- **Parent Questionnaire**
- **Healthix Consent**
- **Privacy Notice Acknowledgement**
- **Authorization for Release of Health Information**

Give the completed forms directly to the School HHLI at Westbury High School or the Nurse's office.

HHLI at Westbury High School is open Monday through Friday 7:30-3:30 PM. Services are provided to students from grades 9th through 12th during the entire year including June - August.

During the summer we offer vaccinations and physical exams for Westbury School District graduated 8th grade students that will be attending Westbury High School.

We look forward to meeting you and we look forward to providing health services to your child. Feel free to visit us at HHLI at Westbury High School or call us at 516-874-1970 for more information.

Sincerely,

The Staff of Harmony Healthcare Long Island at Westbury High School

HHLI School-Based Health Center Parental Consent Form

☐**Roosevelt High School** ☐ **Freeport High School** ☐ **Westbury High School**

Please know that your child can use the School-Based Health Center and see your other doctors. Signing this consent **does not** change your insurance, **does not** change your private doctor, and does not effect the number of times your child can see their private doctor.

Student Information

Student First Name:_____
Student Last Name:_____
Date of Birth: ___/____/_____ **Grade:** _____
Sex: ☐ Male ☐Female
Student Address:_____
_____
City State Zip Code

Student Cell Phone:_____
Student Email:_____

***Student Social Security**: _____-_____-_____
(*optional field: Used for insurance purposes only)

Race: ☐Asian ☐Black or African American ☐White ☐Other ☐Decline to Specify
Ethnicity: ☐Hispanic ☐Not Hispanic ☐Decline to Specify

List the student's primary care provider, if they have one
Name:_____
Telephone: _____
Address:_____

Parent/ Guardian Information

Last Name:_____ **First Name:**_____
Date of Birth: ____/____/____
Home/Work Tel: _____
Cell Phone:_____
Email: _____

Last Name:_____First Name:_____
Date of Birth: ____/____/____
Home/Work Tel: _____
Cell Phone:_____
Email: _____

If legal guardian, relationship to the student:
☐ Grandparent ☐ Aunt/ Uncle ☐ Foster Parent
☐ Other:_____

Preferred Language of Parent/ Guardian:_____

ADDITIONAL EMERGENCY CONTACT

Name:_____
Relationship to Student:_____
Telephone:_____

PHARMACY INFORMATION

Indicate the Pharmacy where we can send prescriptions.
Pharmacy:_____
Pharmacy Address: _____
Pharmacy Tel:_____

I HEREBY DESIGNATE HHLI SCHOOL-BASED AS MY PRIMARY CARE PROVIDER ☐ YES ☐ NO

INSURANCE INFORMATION

The School-Based Health Center provides care to students whether or not they have insurance. If the student has Medicaid or other insurance, it is important to inform the School-Based Health Center in order to bill for the services. There is no out-of-pocket cost to you for the services provided by the School-Based Health Center.

Does your child have health insurance?
☐**Yes,** Health Plan Name:_____ Member ID/ Policy Number:_____
Does your child have Medicaid? ☐**Yes,** Medicaid ID Number:_____
☐**No,** My child does not have health insurance.

Every child in New York can get health insurance, even if they are undocumented immigrants. If your child is not insured, the School-Based Health Center can connect you with a Public Health Insurance enroller.
If your child does not have health insurance, would you like a representative to contact you to assist with getting health insurance? ☐Yes ☐ No

PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES — Please read Box 1

I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the School-Based Health Center of HHLI. I grant permission for my child to enroll in the School-Based Health Center in the High School. I understand the consent form will remain in effect as long as my child is enrolled at the High School unless I notify the Health Center in writing. I understand I may revoke my consent at any time.

X_____ _____

Signature of Parent/Guardian **Date**

SCHOOL-BASED HEALTH CENTER SERVICES — Box 1

I hereby give my consent for my son/daughter to receive "no-cost" health care provided by the physician, nurse practitioner and other State-Licensed Health professional of the HHLI School-Based Health Program and low cost care at the HHLI School-Based Health Center, to include the following comprehensive health services as part of a school health program sponsored by New York State Department of Health.

- Complete physical checkups and lab tests, including sports physical
- Hearing, Vision, Scoliosis and blood pressure screening
- Immunizations and First Aid services
- Prescription and treatment for illnesses
- Verification of pregnancy
- Dental referrals
- Testing and treatment for sexually transmitted diseases
- Health education, Nutrition and weight problems
- Counseling for school and personal problems
- Provision of health services at any of the Health Centers after school and during school vacations

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. I understand that confidentiality between the student and the medical team will be ensured in the specific service area and will not be discussed with the parent or guardian unless the student agrees. The Staff of HHLI School-Based Health Center considers parental involvement important. The staff will encourage the student to involve his/her parent/guardian in counseling and medical services.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES — Box 2

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

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

Signature of Representative:_____ **Date**:_____

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

Relationship to Patient: _____
(If Applicable)

Reports to NYS Immunization Information System — Box 3

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

Signature of Representative:_____ **Date**:_____

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1 Post Road Westbury,
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Harmony Healthcare Long Island at Westbury High School

A Joint Program of the Westbury Union Free School District and the HHLI

Initial Parent/Guardian Questionnaire

Date: _____ Grade: _____
Name: _____ Date of Birth: _____ Sex: _____

Name of person completing form: _____ Relationship: _____

Health History

Last physical exam: _____ Any change in health in past year? _____
Allergies to medicines: _____ to foods: _____ Other: _____
Medications: Prescription: _____ Over the counter: vitamins/supplements: _____
Birth weight: _____ Did your child have any complications at birth? _____ During or after birth? _____

Any overnight hospitalizations?
Yes ☐ No ☐
Any surgery?
Yes ☐ No ☐
Any serious or sports related injury?
Yes ☐ No ☐

If yes, please give age, and reason for hospital stay:
_____
_____
_____
If yes, explain: _____
_____

Please check if your child or a family member ever had any of the following?

	Child		Family Member	
	Yes	No	Yes	No
Alcohol/Drug use	☐	☐	☐	☐
Anemia or Blood disorder	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Birth defect	☐	☐	☐	☐
Bladder or Kidney infection	☐	☐	☐	☐
Blood pressure or heart problems	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/seizures	☐	☐	☐	☐
Fractures (broken bones)	☐	☐	☐	☐
Headaches/Migraines	☐	☐	☐	☐
Head Injury/Concussion	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Mononucleosis	☐	☐	☐	☐
Murmurs (Heart)	☐	☐	☐	☐
Rheumatic Heart Disease	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Ulcer or Digestion problems	☐	☐	☐	☐
Mental Illness or Depression	☐	☐	☐	☐
Other illnesses	☐	☐	☐	☐

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Further Medical History Questions:

Has any family member had a history of sudden death or heart attack before the age of 50?

Have there been any changes in your family in the past year, such as the following?

- ____ Serious illness
- ____ Move to new house/community
- ____ Deaths
- ____ Marriage
- ____ Divorce
- ____ Other

Parent/Guardian Concerns:

Do you have any specific concerns about your child/adolescent?

Healthix - Authorization for Access to Patient Information

Patient Name:	**Date of Birth:**
Patient Address:	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Harmony Healthcare Long Island to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ 1. **I GIVE CONSENT** for Harmony Healthcare Long Island to access ALL of my electronic health information through Healthix to provide health care.
☐ 2. **I DENY CONSENT** for Harmony Healthcare Long Island to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative:	Date:
Print Name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):

516-296-3742
www.harmonyhealthcareli.org

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used only for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification**. Check whether you have health insurance and what it covers.
   - **Care Management Activities**. These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities**. Evaluate and improve the quality of medical care provided to you and all patients.
2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

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

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by checking Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information**. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Harmony Healthcare Long Island at 516-296-3742; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, in case of a minor until he/she turns 18 years of age, or until 50 years after your death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

HarmonyHealthcare Long Island

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

I, or my authorized representative, request that health information regarding my care and treatment as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S) SPECIFIED IN ITEM 9 (b).**

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

Delivery Details: (**check one**)

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

☐ Pick up at HHLI Roosevelt 380 Nassau Road Roosevelt NY 11575 ☐ Other (please explain): _____ _____

9 (a). Specific information to be released:

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

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

☐ Other: _____ _____

Include: (*Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

HarmonyHealthcare
Long Island

Authorization to discuss health information

9 (b). ☐ By initialing here _____ I authorize _____

(Name of individual health care provider)

to discuss my health information with _____

_____

Relationship to patient: _____

10. Reason for release of information: ☐ At request of individual ☐ Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All Items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____

Signature of Patient or representative authorized by law. Date:

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Harmony Healthcare Long Island, Inc.
Nassau University Medical Center
A. Holly Patterson Extended Care Facility

Collectively the "Health System"

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

POLICY STATEMENT

This Health System is committed to maintaining the privacy of your protected health information ("PHI"), which includes electronic PHI, in accordance with the provisions of the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health Act, and their regulations (collectively the "HIPAA Rules"), which includes information about your medical condition and the care and treatment you receive from the Health System. This Notice details how your PHI may be used and disclosed to third parties to carry out your treatment, payment for your treatment, health care operations of the Health System, and for other purposes permitted or required by law and the HIPAA Rules. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

1. The Health System may use and/or disclose your PHI for treatment, payment for your treatment, and health care operations of the Health System. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

(a) Treatment - In order to provide, coordinate and manage your health care, the Health System will provide your PHI to those health care professionals, whether on the Health System's staff or not, directly involved in your care so that they may understand your medical condition and needs, and provide advice or treatment (e.g., a specialist or laboratory). For example, a physician treating you for a condition such as arthritis may need to know what medications have been prescribed for you by the Health System's physicians.

(b) Payment - In order to get paid for some or all of the health care services provided to you, the Health System will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Health System may need to tell your insurance plan about the need to hospitalize you so that the insurance plan can determine whether or not it will pay for the expense.

(c) Health Care Operations - In order for the Health System to operate in accordance with applicable law and insurance requirements and in order for the Health System to continue to provide quality and efficient care, it may be necessary for the Health System to compile use and/or disclose your PHI. For example, the Health System may use your PHI in order to evaluate the performance of the Health System's personnel in providing care to you or to support the business activities of the Health System. These operational activities may include: quality assessment and improvement activities, training programs involving students, trainees, or practitioners under supervision, and general administrative activities.

AUTHORIZATION NOT REQUIRED

1. In addition to treatment, payment, and health care operations, the Health System may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

(a) De-identified Information - Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate, which is someone who the Health System contracts with to provide a service necessary for your treatment, payment for your treatment, and health care operations (e.g., billing service or transcription service). The Health System will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and its subcontractors will appropriately safeguard your PHI.

(c) To You or a Personal Representative - To you or to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

(e) Schools - Proof of immunization(s) about a student or prospective student may be disclosed to a school without written authorization if state law requires the school to have immunization records. The agreement to the disclosure may be given in either written or oral format and documented in the patient's medical record.

(f) Food and Drug Administration - If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Health System is required by law to make such disclosure. If the Health System is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Health System believes that you have been the victim of abuse, neglect or domestic violence.

Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceedings • For example, the Health System may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Health System; and (6) a medical emergency (not on the Health System's premises) has occurred, and it appears that a crime has occurred.

(k) Coroner or Medical Examiner - The Health System may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Health System may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Health System is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

(n) Avert a Threat to Health Or Safety - The Health System may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o)Specialized Government Functions - When the appropriate conditions apply, the Health System may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Health System may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

(p) Inmates - The Health System may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safely of other individuals or inmates.

(q) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Health System may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(r) Disaster Relief Efforts - The Health System may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

(s) Required by Law. If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

As detailed in the HIPAA Rules, certain uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes (as described in the "Marketing" section of this Privacy Notice), and disclosures that constitute a sale of PHI require a written authorization from you, and other uses and disclosures not otherwise permitted as described in this Privacy Notice will only be made with your written authorization, which you may revoke at any time as detailed in the "Your Rights" section of this Privacy Notice.

SIGN-IN-SHEET

The Health System may use a sign-in sheet at the registration desk. The Health System may also call your name in the waiting room when your physician is ready to see you.

PATIENT DIRECTORY

Unless you object, the Health System will include general information in its directories of individuals, including your name, location in the facility, your condition described in general terms, and your religious affiliation. The directory information, except for your religious affiliation, will be released to persons who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.

APPOINTMENT REMINDER

The Health System may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Health System will try to minimize the amount of information contained in the reminder. The Health System may also contact you by phone and, if you are not available, the Health System will leave a message for you.

TREATMENT ALTERNATIVES/ BENEFITS

The Health System may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

MARKETING

The Health System may only use and/or disclose your PHI for marketing activities if we obtain from you a prior written Authorization. "Marketing" activities include communications to you

that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. However, marketing does not include, for example, sending you a newsletter about this Health System. Marketing also includes the receipt by the Health System of remuneration, directly or indirectly, from a third party whose product or service is being marketed to you. The Health System will inform you if it engages in marketing and will obtain your prior Authorization.

FUNDRAISING

The Health System may use and/or disclose some of your PHI in order to contact you for fundraising activities supportive of the Health System. Any fundraising materials sent to you will describe how you may opt out of receiving any further communications.

ON-CALL-COVERAGE

In order to provide on-call coverage for you, it is necessary that the Health System establish relationships with other physicians who will take your call if a physician from the Health System is not available. Those on-call physicians will provide the Health System with whatever PHI that they create and will, by law, keep your PHI confidential.

FAMILY/FRIENDS

The Health System may disclose to your family members, other relatives, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Health System may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) of a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) The Health System may use or disclose your PHI if you agree, or if the Health System provides you with opportunity to object and you do not object, or if the Health System can reasonably infer from the circumstances, based on the exercise of its judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Health System will, in the exercise of its judgment, decide whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

YOUR RIGHTS

1. You have the right to:

- **a)** Revoke any Authorization, in writing, at any time. To request a revocation, if you are a patient at Nassau University Medical Center, you must submit a written request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses).

b) Request restrictions on certain uses and/or disclosures of your PHI as provided by law. The Health System is not obligated to agree to every requested restriction, except to the extent required by the HIPAA Rules or by law. To request restrictions, you must submit a written request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses). In your written request, you must inform the Health System of what information you want to limit, whether you want to limit the Health System's use or disclosure, or both, and to whom you want the limits to apply. If the Health System agrees to your request, the Health System will comply with your request unless the information is needed in order to provide you with emergency treatment.

c) Restrict certain disclosures of PHI about you to a health plan where you pay out of pocket in full for the health care item or service.

d) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses). The Health System will accommodate all reasonable requests.

e) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses). In certain situations that are defined by law, the Health System may deny your request, but you will have the right to have the denial reviewed. The Health System can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

f) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses). You must provide a reason that supports your request. The Health System may deny your request if it is not in writing, if you do not provide a reason in support of your

request, if the information to be amended was not created by the Health System (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Health System, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Health System's denial, you will have the right to submit a written statement of disagreement.

g) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you must submit your request in writing to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses).The request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Health System may charge you for the cost of providing additional lists in that same twelve (12) month period. The Health System will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

h) Receive a paper copy of this Privacy Notice from the Health System upon request to the Medical Records Department, NHCC, 2201 Hempstead Turnpike, East Meadow, New York 11554. If you are a resident of A. Holly Patterson Extended Care Facility ("AHP") you may direct your request to Medical Records Department, AHP, 875 Jerusalem Avenue, Uniondale, New York 11553. If you are a patient of any of the Harmony Healthcare Long Island locations, you must submit your request in writing to the Health Center where you were treated (see below list with addresses).

i) Be notified following a breach of your Unsecured PHI (as such term is defined by the HIPAA Rules).

Complain to the Health System or to the Secretary of Health and Human Services if you feel that your privacy has been violated. You may contact a regional office of the Office for Civil Rights, which can be found at www.hhs.gov/ocr/office/about/rgn-hqaddresses.html. To file a complaint with the Health System, you must contact the Health System's Privacy Officer. All complaints must be in writing.

To obtain more information, or have your questions about your rights answered; you may contact the Health System's Privacy Officer, Karen G. Leslie, at 2201 Hempstead Turnpike, East Meadow, New York 11554 at (516)-572-4754.

HEALTH SYSTEM'S REQUIREMENTS

1. The Health System:

(a) Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Health System's legal duties and privacy Health Systems with respect to your PHI.

(b) Is required to abide by the terms of this Privacy Notice, which is currently in effect.

(c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

(d) Will not retaliate against you for making a complaint.

(e) Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

(f) Will post this Privacy Notice on the Health System's web site, if the Health System is maintaining a web site.

(g) Will provide this Privacy Notice to you by e-mail if you so request. However, you also have the right to obtain a paper copy of this Privacy Notice.

EFFECTIVE DATE

This Notice takes effect September 23, 2013. The prior Notice's effective date was April 14, 2003.

PRIVACY NOTICE

LIST OF HEALTH SYSTEM MEMBERS

Harmony Healthcare Long Island at Elmont- 161 Hempstead Turnpike, Elmont, NY 11003
Harmony Healthcare Long Island at Hempstead- 135 Main Street, Hempstead, NY 11550
Harmony Healthcare Long Island at Freeport- 101 S Bergen Place, Freeport, NY 11520
Harmony Healthcare Long Island at Roosevelt- 380 Nassau Road, Roosevelt, NY 11575
Harmony Healthcare Long Island at Oceanside- 3227 Long Beach Road suite 2, Oceanside, NY 11572
Harmony Healthcare Long Island at Westbury- 682 Union Avenue, Westbury, NY 11590
Harmony Healthcare Long Island at Roosevelt High School
Harmony Healthcare Long Island at Freeport High School
Harmony Healthcare Long Island at Westbury High School
Nassau University Medical Center
A. Holly Patterson Extended Care Facility

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

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

(1) Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor;

(2) Be treated with consideration, respect and dignity including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access;

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;

(17) When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center;

(18) View a list of the health plans and the hospitals that the center participates with; and

(19) Receive an estimate of the amount that you will be billed after services are rendered.

Department of Health

Patients' Rights, 10 NYCRR, Section 751.9