



RENSSELAER COUNTY  
DEPARTMENT OF MENTAL HEALTH

Steven F. McLaughlin  
County Executive

Katherine G. Alonge-Coons LCSWR  
Commissioner

**NOTICE OF PRIVACY PRACTICES  
NEW YORK STATE'S "SURPRISE BILL" LAW,  
RECIPIENT RIGHTS,  
CONSENT FOR TREATMENT**

I acknowledge that I have read the Rensselaer County:

**Notice of Privacy Practices,**

**New York State's "Surprise Bill" Law**

**Recipient Rights**

**Hixny Consent**

**PSYCKES Consent**

I also consent to the disclosure of personally identifiable information for treatment, payment and normal healthcare business operations of the covered program in regard to myself and others noticed below for whom I can legally consent.

I understand I may request a copy of these policies at any time throughout my episode of care.

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

I, or my minor child \_\_\_\_\_ accept, understand and agree to abide by the contents and terms of this agreement, and further, consent to participate in the evaluation and/or treatment. I understand that I may withdrawal from treatment at any time.

\_\_\_\_\_  
Printed Name of Enrollee/Patient

\_\_\_\_\_  
Signature - describe legal relationship to others

\_\_\_\_\_  
Date

*"Providing quality care to empower and help all persons."*



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse; the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from re-disclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV information and you may request a list of persons authorized to re-release such information. The information exchanged may be verbal or written.

Name or Title of person or organizations releasing and/or obtaining information:

Name or Title of person or organizations releasing and/or obtaining information:

Between: Rensselaer County Department of Mental Health Children's Clinic

And: \_\_\_\_\_

Description of information including date(s): Medical records, oral/written communication regarding treatment, date of last physical exam, copies of any recent bloodwork, information regarding chronic physical health issues, medication list, compliance, and any

1. other information pertaining to mental health

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable space next to the type of information.

\_\_\_ HIV/AIDS information

\_\_\_ Genetic testing information

\_\_\_ Mental health information

\_\_\_ Drug/alcohol diagnosis, treatment, or referral information

2. Purpose of the use/disclosure: \_\_\_\_\_

3. The person/program requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

4. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, enrollment, etc.

5. I understand that I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it.

6. I may remove this authorization at any time by notifying the Rensselaer County Dept. of Mental Health in writing, but if I do it will not have any effect on any actions they took before they received the revocation.

This authorization will expire: Upon Discharge from Care

HIV specific information:

For questions/complaints regarding HIV discrimination, call the New York State Division of Human Rights at (518) 474-2705 or the New York City Commission on Human Rights at (212) 306-7450.

Federally protected substance abuse information:

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature of Patient or legal representative: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Printed Name of patient's legal representative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ (Print Name)

\_\_\_\_\_ (Signature)



## Hixny Electronic Data Access Consent Form

### Rensselaer County Department of Mental Health

In this Consent Form, you can choose whether to allow **Rensselaer County Department of Mental Health** to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as 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 **Rensselaer County Department of 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, **Rensselaer County Department of 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, **Rensselaer County Department of 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. This kind of sharing is called ehealth or health information technology (health IT).

**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 Rensselaer County Department of Mental Health to access ALL of my electronic health information through Hixny in connection with providing me any health care services, including emergency care.**
- I DENY CONSENT for Rensselaer County Department of Mental Health to access my electronic health information through Hixny for any purpose, *even in a medical emergency.***

***NOTE: UNLESS YOU CHECK THIS 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 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)



Rensselaer County Department of Mental Health

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to www.psyckes.org, and click on About PSYCKES, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
Your health services paid for by Medicaid;
Your health care history, such as illnesses or injuries treated, test results and medicines;
Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
"I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES - or get it from another provider - when state and federal laws and regulations allow it. For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. Please check 1 box only.

- I GIVE CONSENT for the provider, and their staff involved in my care, to access my health information in connection with my health care services.
I DON'T GIVE CONSENT for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

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 Patient (if applicable)

1 Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").



Client ID: \_\_\_\_\_  
Date Completed: \_\_\_\_\_

## RENSSELAER COUNTY DEPARTMENT OF MENTAL HEALTH

### Client Health Screening Form

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

What is the issue that brings you in for services? How long has it been going on? In what areas of the child's life is it present (home, school, friendships)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Sex (as listed on insurance card): Male Female

Child's Gender: Male Female Other \_\_\_\_\_

Child's Race: American Indian/Alaskan Native Asian Pacific Islander Black Hispanic White Other \_\_\_\_\_

Child's Ethnicity: Not of Hispanic Origin Hispanic Origin Cuban Mexican/Mexican-American Puerto Rican Other \_\_\_\_\_

Primary Home Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Phone type (circle one): Cell Home Work

Father's Name: \_\_\_\_\_ Level of Education: \_\_\_\_\_

Address (if different from child's): \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Preferred Telephone number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Level of Education: \_\_\_\_\_

Address (if different from child's): \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Preferred Telephone number: \_\_\_\_\_

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

Family Status: Married Separated Divorced Living Together Stepmother Stepfather Foster Parents

DSS Custody Other (please specify) \_\_\_\_\_



Do you have concerns that your child is? (circle all that apply):

Smoking cigarettes	Using e-cigarettes/vaping	Using drugs	Drinking alcohol
Is the client a current tobacco user or smoker? Yes (smoker)	Yes (smokeless)	No	
If yes to the above question, is client interested in quitting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Does anyone in the household smoke cigarettes/use tobacco?	Yes	No	

**FAMILY HISTORY**

Please list any serious or chronic illnesses suffered by the child’s parents, siblings, or extended family:

---



---



---



---

Is any close relative (parent, grandparent, sibling) diagnosed or treated for a mental health problem? Please give diagnosis and explanation:

---



---



---



---

Person completing application: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

-----

For Office Use Only:

Therapist Review by: \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber Review by: \_\_\_\_\_

Date: \_\_\_\_\_



Welcome. This screening tool is used to support you with your health goals. There are no wrong answers. Your responses are completely confidential and do not affect your benefits and services.

Note: The screening tool should not be completed if you filled one out in the last 3 months.

In the last 12 months, did you ever eat less than you felt because there wasn't enough money for food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the last 12 months, has your utility company shut off your service for not paying your bills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you worried that in the next 2 months, you may not have stable housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the last 12 months, have you needed to see a doctor, but could not because of cost?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever need help reading hospital materials?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you afraid you might be hurt in your apartment building or house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**To be completed by CLIENTS age 12 and over ONLY  
(PARENTS -- please allow YOUTH to answer questions)**

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

\_\_\_\_\_ Not at all    \_\_\_\_\_ Somewhat difficult    \_\_\_\_\_ Very difficult    \_\_\_\_\_ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?    Yes     No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or make a suicide attempt?    Yes     No