Hometown Health Centers

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received a copy of Hometown Health Centers' Notice of Privacy Practices. This notice describes how Hometown Health Centers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

RELEASE OF INFORMATION

- We participate in (i) the Alliance for Better Health Care, LLC, a Performing Provider System (PPS) and/or (ii) the Innovative Health Alliance of New York, LLC an Accountable Care Organization (ACO) and/or (iii) the Innovative Health Alliance of New York, IPA, LLC. These are NYS regulated programs created to coordinate your care and to reduce unnecessary or duplicate medical procedures or tests. By signing this form, you allow us to share your health information with other health care providers who are treating you and who participate in the PPS or ACO, in order to coordinate your care. Note that the health information you are allowing us to share may include HIV/AIDS information, mental health conditions, and/or information about sexually transmitted diseases.

ACKNOWLEDGEMENT OF RECEIPT OF HANDBOOK FOR ADVANCE DIRECTIVES

- I acknowledge that I have received a copy of "Planning Your Health Care in Advance" New York State's Booklet on Advance Directives and Health Care Proxy Form.

GENERAL CONSENT FOR ELECTRONIC PRESCRIBING

- I give my permission for Hometown Health Centers to electronically prescribe medication on my behalf to the pharmacy of my choice and to access my electronic prescription information and history.

GENERAL CONSENT FOR TELEHEALTH TREATMENT

- I hereby authorize and request providers used by Hometown Health Centers via telehealth services to provide appropriate treatment.

GENERAL CONSENT FOR TREATMENT

- I hereby authorize and request providers at Hometown Health Centers to provide appropriate treatment.

_____ _____

Patient Name **Patient's Date of Birth**

_____ _____

Signature of Patient, Parent/Guardian, Legal Representative **Date**

_____ _____

Print Name **Relationship to Patient**

Witness/Hometown Health Centers Employee: _____

Date: _____