PATIENT INFORMATION

Date: _____ MRN: _____ *(Office Use Only)*

Patient's Name: _____ Date of Birth: _____ Age:_____

Sex: ___ Male___ Female Patient/Contact Email Address _____

Street Address _____ Apt# _____

City: _____ State_____ Zip Code:_____ County: _____

Patient's Home Phone Number: ( ) _____ Okay to call: ___ Yes ___ No

PARENT INFORMATION / PERSONS TO BE CONTACTED IN CASE OF EMERGENCY:

***Mother's or Father's Name*:** _____ Relationship: _____

Address (if different): _____

Home Phone:( )_____ Work Phone:( )_____ Cell Phone: ( )_____

***Other Parent's or Contact's Name* :** _____ Relationship:_____

Address (if different): _____

Home Phone:( )_____ Work Phone:( )_____ Cell Phone: ( )_____

Primary Care Physician: _____ Phone Number: ( )_____

Physician Address:_____

Outpatient Therapist: _____ Phone Number: ( )_____

Therapist Address:_____

INSURANCE INFORMATION

***Primary Insurance* –** Name of Company: _____

Policy #: _____Group #: _____ Insurance Company Phone #:_____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Employer:_____ Relationship to Patient:_____

Subscriber's Address(if different than patient): _____

Secondary Insurance – Name of Company: _____

Policy #: _____Group #: _____ Insurance Company Phone #:_____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Employer:_____ Relationship to Patient:_____

Subscriber's Address(if different than patient): _____

_____ /_____ _____ _____ _____

Patient, if 18 or older *Signature* *Printed Name* Date Witness Date

_____ /_____ _____ _____ _____

Parent (or Guardian) *Signature* Parent (or Guardian) *Printed Name* Date Witness Date

Four Winds SARATOGA a psychiatric health system **DOCUMENT SIGNATURE PAGE**	Patient Name: Date of Birth:

CONSENT FOR TREATMENT

I am requesting voluntary admission to the Partial Hospital Program or Intensive Outpatient. I understand that as a voluntary patient, I can choose to discontinue the program at any time for any reason. However, program staff strongly encourages patients to discuss their intention to leave the program prior to making the final decision. I have received a Patient Handbook, which includes patient rights and responsibilities, as well as the programs grievance procedure. I understand that I may go to any clinical staff member if I have questions or concerns about any of my rights or responsibilities. The risks and benefits of the Program have been fully explained to me and I am choosing to participate in the program, being fully aware of these risks and benefits.

I have received a copy of the following documents (check all documents given to the patient):

- ☒ Four Winds Saratoga Patient Bills Of Rights
- ☒ Notice of Privacy Practices
- ☒ Patient Handbook
- ☐ An Important Message from Medicare

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I hereby consent to the taking of my photograph for identification purposes only. I understand that, upon discharge, my photograph will be kept by Four Winds Saratoga and filed in my medical record.

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I have discussed the above with the patient and his/her family (when available) and he/she has indicated an understanding of the rights guaranteed to him/her while a patient at Four Winds Saratoga.

Patient refuses to discuss above (check if applicable)	☐ Yes	☐ No
Patient refused handouts (check if applicable)	☐ Yes	☐ No

Staff Signature:	**Date/time:**

FOUR WINDS - SARATOGA
HEALTH SCREENING

PATIENT NAME _____

MEDICAL RECORD NO. _____ DOA: _____

AGE _____ DATE OF BIRTH _____

ADMITTING DIAGNOSIS _____

LEVEL OF CARE: ☐ PHP ☐ IOP

PRIMARY CARE PROVIDER

NAME CURRENT PRIMARY CARE PROVIDER--PHYSICIAN OR CLINIC W		DATE LAST PHYSICAL EXAM
ADDRESS	CITY/STATE	PHONE NUMBER

ALLERGIES	HEIGHT	WEIGHT

HEALTH CONDITIONS ☐ NONE

	Current	History	Treating Physician for Current Condition
1. Chicken Pox			
2. Asthma			
3. Hepatitis			
4. Tumor			
5. Mumps			
6. Scarlet Fever			
7. Kidney Disease			
8. Tuberculosis			
9. Diabetes			
10. Sexually Transmitted Disease			
11. Measles / Rubella			
12. Hypertension			
13. Heart Disease			
14. Ulcer			
15. Stroke			
16. Glaucoma			
17. Head Injury			
18. Seizures			
19. Thyroid Problem			
20. Goiter			
21. High Cholesterol			
22. Other			

HAVE YOU EXPERIENCED THE FOLLOWING? IF YOU HAVE PLEASE EXPLAIN

		Yes	No		Yes	No	Comments
GENERAL	Weight Change			Appetite Change			
	Fatigue			Night Sweats			
	Rash			Allergies			
HEENT	Blurred Vision			Bleeding Gums			
	Headaches			Nosebleeds			
	Earaches			Sore Throat			
	Sinus Trouble						
RESPIR-ATORY	Cough			Difficulty Breathing			
	Wheezing						
CARDIO-VASCULAR	Chest Pain			Swelling of Ankles			
	Tendency to bleed or bruise easily			Palpitation			
	Shortness of Breath on Exercise						
GASTRO-INTESTINAL	Heartburn			Rectal Bleeding			
	Nausea			Diarrhea			

	Vomiting			Constipation			
	Difficulty Swallowing						
URINARY	Frequency			Pain on Urination			
	Urgency			Blood in Urine			
	Loss of urine when sneeze, cough or laugh			Has frequency of urination changed?			
MALE GENITAL	Discharge from Penis			Changes in Testes or Scrotum			
	Undescended Testes			Lesions on Penis			
	Sexually transmitted disease						
FEMALE GENITAL	Date of Last Period			Menopause			
	Irregular Periods			Dysmenorrhea			
	Discharge			Heavy Breasts			
	STDS			Vaginal Discomfort			
	Disch. from nipples			Lumps in breast			
	Tender breasts						
OBSTET-RICAL	# of pregnancies			# of children			
	Abortions			Cesarean			
	Miscarriage						
NEURO-LOGICAL	Dizzy spells			Fainting			
	Numbness			Weakness			
	Difficulty with Coordination			Difficulty with Speech			
MUSCULO-SKELTETAL	Painful Joints			Swelling			
	Back Pains			Old Injury			
Signature of Patient:							**Date:**
MD/NPP Signature:							**Date/Time:**

Four Winds HOSPITALS

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Fax: (518) 580-1514

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Integrated Assessments/Psychiatric Assessment
- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

This information will be used for the following purpose(s):

- ☐ Evaluation and Continuing Treatment / Coordinating Care
- ☐ Educational Placement / Other Educational Concerns / Billing School District for Education
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

Four Winds SARATOGA a psychiatric health system **TELEMEDICINE APPOINTMENT INFORMED CONSENT FORM**	Patient Name DOB MRN

Telepsychiatry uses two-way communication through audio and video equipment to provide mental health services to you at a distance. Telepsychiatry allows you and staff at different locations to interact and provide care without the need to travel long distance.

Expected Benefits

Telepsychiatry can be a benefit to you, when on-site services are not available because of the distance, location, time of day, or availability of resources. Some benefits to Telepsychiatry are:

- Improved access to care
- Timely services
- Improved coordination of care
- Improved treatment of care

Potential Risks

There are possible risks with the use of telepsychiatry. These risks could include:

- Delays in treatment due to equipment failure
- Poor picture and delays in the video
- Potential data transmission problems that happen in very rare instances, but could lead to a breach of your information
- A lack of information that might be available in a face to face visit but not in a Telepsychiatry session may result in errors in medical judgment

You have the right to:

If you choose to participate in Telepsychiatry services, you are given additional Client Rights including being informed of:

- What trained staff will be available to you and providing you services at the distant site and who can help in an emergency.
- How the Telepsychiatry equipment works and the purpose of videoconferencing technology.
- Who is in the room at each location during the Telepsychiatry session
- Your opportunity to decide about who will be in the room with you during telepsychiatry sessions, as well as the right to ask non-medical personnel to leave the room at any time if not needed for safety concerns.

Failure of Transmission

In the event your session is dropped as a result of transmission or equipment failure someone from the office will contact you. We would need to be sure that any alternative contact methods are encrypted and secure. This may mean a follow up in-person appointment or an additional telepsychiatry session to complete the appointment.

I understand this service is not the same as a direct provider visit, because I will not be in the same room as the provider performing the service. Parts of my treatment which involve physical tests/examinations such as taking my vital signs and blood pressure will not be completed. I understand that my telepsychiatry provider will be my local provider I would normally see in the office setting. Also,

Four Winds SARATOGA a psychiatric health system **TELEMEDICINE APPOINTMENT INFORMED CONSENT FORM**	Patient Name DOB MRN

- I have the right to refuse or withdraw my consent to telepsychiatry sessions at any time, without affecting my right to future care or treatment.
- I understand this is temporary due to the recent COVID19 state and federal restrictions put in place.
- If my provider decides my health care can no longer be managed through telepsychiatry, services may be discontinued. Other options for my care will be discussed with me.
- Telepsychiatry sessions shall not be recorded without my consent.
- Written medical information and telepsychiatry sessions are kept confidential the same as in-person medical records.
- I agree to allow individuals other than my provider and remote provider to be present during my telepsychiatry service to operate the video equipment, if necessary. Also, if additional persons are needed for safety concerns, then my permission may not be needed.

☐ We have read the Telepsychiatry consent form to the patient/legal guardian and we witnessed the consent of telepsychiatry through the Four Winds Partial and/or Intensive Outpatient Program. The patient/family has had an opportunity to ask questions which I've answered to the best of my knowledge.

Staff1: _____ Date/Time _____

Staff2: _____ Date/Time _____

Dear Patient/Family,
Upon receipt of this form, please read through the consent above and the statement below. Sign and return to the office at your earliest convenience. Please know you have given verbal consent for your first session. After reading this form, should you change your mind please notify the staff immediately.

Four Winds Saratoga
Partial / Intensive Outpatient Program
30 Crescent Ave Saratoga Springs NY 12866
(518) 584 - 3600

I have read and understand the information provided above regarding telepsychiatry. I have discussed the expected benefits, potential risks, as well as possible alternatives to telepsychiatry with my provider. All of my questions have been answered to my satisfaction. I hereby authorize Four Winds Partial / Intensive Outpatient to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient/Legal Guardian: _____Date:_____

Print Name of Patient/Legal Guardian: _____

Four Winds SARATOGA
a psychiatric health system

FINANCIAL AGREEMENT

PATIENT NAME
DATE
MEDICAL RECORD NUMBER
PATIENT ACCOUNT NUMBER

LIABILITY FOR LOSS OF VALUABLES

I hereby release the Hospital and its staff from all responsibility for any loss or damage to personal property or money not deposited with the Hospital. I further understand that valuable articles should be sent home and that money should be kept in a personal account in the business office.

RESPONSIBILITY FOR SPECIALIZED SERVICES

It is my understanding that the psychiatric and basic medical care of the above named patient is provided by Four Winds Hospital and Medical staff. However, if specialized medical services not provided at Four Winds Hospital are indicated, I agree that the cost of such medical consultation / treatment will be my responsibility.

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospital all my right, title and interest, including benefit of payment to which I am or may be entitled from_____ insurance company or insurer pursuant to policy # _____ or from any governmental agency, other insurance carrier and/or their agents, or others who are financially responsible for the hospitalization and medical care and services rendered to me or my dependent at Four Winds Hospital.

FINANCIAL AGREEMENT AND GUARANTEE

We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospital of the full and entire amount of any and all bills not paid by our hospitalization insurance plan, private or governmental, or combination of plans. I understand that all such bills are due and payable upon presentation at the rate of $325 (AIOP) dollars per day. Payment may be demanded at any time from any of the undersigned and failure to demand payment of the patient shall not be a prerequisite to the guarantors immediate responsibility for payment. This agreement shall be governed by the laws of the State of New York as a contract deemed executed in New York and to be performed in New York. Any lawsuit brought to enforce this agreement shall be brought only in a state or federal court setting in New York, Albany or Saratoga Counties, and each party hereto expressly consents to the jurisdiction and venue of each such court. We agree to pay the hospital's costs and expenses in enforcing this agreement, including the hospital's reasonable attorneys' fees. This document constitutes the complete agreement of the parties. We acknowledge that we have not relied on statements, promises, or representations, oral or written, other than as contained herein.

WE HAVE READ THIS AGREEMENT AND WE FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE AND HAVE RETAINED A COPY OF THIS AGREEMENT.

ALL PARTIES MUST SIGN AS FOLLOWS

Patient (if 18 or over)	Mother	Father
Spouse	Other legally responsible party	Date

Four Winds SARATOGA
a psychiatric health system

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____

Date of Birth _____

INSURANCE COMPANY/MANAGED CARE COMPANY

FOUR WINDS SARATOGA

30 CRESCENT AVENUE

SARATOGA SPRINGS, NEW YORK 12866

PHONE: (518) 584-3600

FAX: (518) 580-1514

I authorize Four Winds Saratoga to: (please check one or both)

☒ obtain from ☒ release to:

Person/Agency:

Address:

City, State, Zip:

Phone: Fax:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Admission/Psychiatric Assessments/ Substance Abuse Assessments
- ☐ Clinical Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ History & Physical, Labs, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Materials/Verbal Academic Reports/School Discharge Summary
- ☐ Immunization Records
- ☒ Billing Issues & Payment Arrangements
- ☐ Other (Specify):

This information will be used for the following purpose(s):

☒ For purposes of billing and/or certification of care
☐ Other (specify):_____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York State law.

Signature of Patient or Legal Guardian	Date
If Signed by Legal Guardian, Relationship to Patient	Signature of Witness (over the age of 18)

☐ I hereby cancel my permission to release information indicated on the reverse side, to the person / organization / facility / program whose name and address is:	☐ I hereby refuse to authorize release of information indicated on the reverse side, to the person/ organization / facility / program whose name and address is:

Signature of Patient	Date Signed	Signature of Witness	Title	Date Signed

Record of information released pursuant to this release.

Date	Specific Document Released	Staff Person Releasing

Hixny Electronic Data Access Consent Form
Four Winds

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

You may use this Consent Form to decide whether or not to allow Four Winds 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, Four Winds'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, Four Winds may not be given access to my medical records through Hixny for any purpose."

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

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

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

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

_____ _____ _____
Print Name of Patient Date of Birth Date

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

_____
Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Four Winds only to:

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

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

What Types of Information About You Are Included

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

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

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

Where Health Information About You Comes From

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

Who May Access Information About You, If You Give Consent

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

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Four Winds at: 607-729-9166 or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

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

Effective Period

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

Withdrawing Your Consent

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

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

Copy of Form

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

Four Winds
SARATOGA
a psychiatric health system

Signature Sheet For

ADVANCE DIRECTIVE

I have a previously created Advance Directive.

MEDICAL ADVANCE DIRECTIVE	☐ YES	☐ NO	☐ YES (I will provide or arrange for my family to provide Four Winds with a copy)
PSYCHIATRIC ADVANCE DIRECTIVE	☐ YES	☐ NO	☐ YES (I will provide or arrange for my family to provide Four Winds with a copy)

I have received the booklet, ***"Planning for Your Mental and Physical Health Care and Treatment"*** which contains the copy of the Advance Directive instructions for completion of an advance directive as prepared by the Resource Center, Inc, a division of the NYS Office of Mental Health. I understand that, if after reading the material I choose to execute an advance directive, I will notify a member of the nursing staff.

Signature of Patient: _____ Date: _____

*If the patient is executing an Advance Directive the MD/NPP must fill out the Advance Directive Assessment form in the patient's medical record.