CONTINUUM HEALTH PARTNERS

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AMBULATORY PATIENT NOTIFICATION RECORD

I acknowledge that I have been given the following Notices as required by State and Federal regulations:

- New York State Patients' Bill of Rights
- Continuum Notice of Privacy Practices
- New York State Health Care Proxy
- Continuum Summary of Policy on Advance Directives
- Continuum Patient Information on Pain Management

and I consent to share my health information for payment, treatment and hospital operations purposes.

Patient/Personal Representative Signature ____________________ Date ____________

Representative Relationship to Patient ____________________ Date ____________

Patient: ☐ Unable to sign
☐ Refuses to sign

Employee Signature ____________________ Date ____________