1150 Youngs Rd
Williamsville, NY 14221
Phone: (716) 636-7979
Fax: (716) 929-0192

Suite 104 & 207

3950 E. Robinson Rd
W. Amherst, NY 14228
Phone: (716) 564-1111
Fax: (716) 929-0194

Suite 106 & 207

Physicians
Michael Dlugosz, M.D.
Stacey Gugino, M.D.
Justin Green, M.D.
Nicholas Pantano, M.D.
Lori Luzi, M.D.
David Pawlowski, M.D.
Michael Freitas, M.D.
Kristina Semidey, M.D.

Nurse Practitioners
Kathleen Barone, F.N.P.
Kimberly MacDonald, F.N.P.
Sharon Tasner, F.N.P.
Elliott Yadon, F.N.P.
Rachel Yadon, F.N.P.

Physician Assistants
Derek Aube-Marchant, PA-C
Jessica Schoenhals, PA-C
Brie Anne Slaughter, PA-C
Stephanie Guize, PA-C
Jillian LaMarca, PA-C
Christine Divita-McKenna, PA-C
Chelsey Milleville, PA-C
Alicia Reimondo, PA-C
Renee Sawka, PA-C
Megan Schifferli, PA-C
Chelsea Percy, PA-C
Emily Kowalski, PA-C
Meaghan Piegay, PA-C

Long-Term Nursing Care/Short-Term Rehab
Ellen Brody, F.N.P.
Danielle Casillo, A.G.N.P.
Leah Gorsline, PA-C
Kimberly Gruber, F.N.P.
Sandy Michel, A.N.P.
Erin Morgan, PA-C
Christina Parkot, F.N.P.
Elizabeth Leiser, F.N.P.
Mallory Furniss, F.N.P.
Mary Nolan, PA
Sara Baker, F.N.P.
Larika Evans, F.N.P.
Veronica Miles, F.N.P.
Chris Laduca, PA
Tiffany Phalen, PA
Timothy Giglio, ANP

Welcome, and thank you for considering Highgate Medical Group, P.C. for your health care needs. We are dedicated to providing you and your family the best in modern medical services in a caring environment. Our goal is to provide you with the highest quality of care and positive patient experience.

In order to expedite your patient registration, please bring the following to your appointment:

- Health Insurance Card
- Photo Identification
- Health Records – including immunizations
- Completed enclosed forms

We offer the following service to make your experience both easy and convenient:

Our phones are turned off and on service during the lunch hour 11:50-1PM daily

- Monday 7-6 PM
- Tuesday 7-6 PM
- Wednesday 7-6 PM
- Thursday 7-6 PM
- Friday 7-5 PM (Office Phones turn off at 4PM)
- Saturday 8AM – 1PM (At our Williamsville location for all patients)
  - Same day sick visits only

We offer the following service to make your experience both easy and convenient:

- Same Day appointment availability
- Our affiliation with McGuire Group gives us access to continue care with short-term rehabilitation and long-term nursing home care coverage
- An online patient portal, for easy communication and appointment scheduling. We anticipate all patients to use the patient portal to effortlessly retrieve test results and communicate directly with your care team.

Your primary care physician plays an important role in the coordination of your care. We have a provider on call 24 hours a day, 7 days a week to help with emergency situations. We can help you identify the most appropriate level of care and refer you to providers that share our philosophy of patient-centered medical care.

We look forward to meeting you!

*Highgate Medical Group, P.C.*

**www.highgatemedical.com**
**You can also make payments on our website!**

**APPOINTMENT DATE:** ________________**TIME:** _____________

**PROVIDER:** ___________________________________

**PATIENT REGISTRATION**

**Patient Name:** ______________________________ **Date of birth:** ____________________

**Mailing Address:** ________________________________________________

**Home Phone Number:** ____________________ **Cell Phone Number:** ____________________

**Email:** ______________________________ **Cell Phone Carrier:** ____________________

**Pharmacy Name & Address:** ________________________________________

**Marital Status:** Single Married Divorced Widowed Legally Separated

**Sex:** Male Female Other **Ethnicity**: Hispanic/Latino Not Hispanic/Latino

**Race**: White/Caucasian Black/African American American Indian/Alaska Native
Asian Native Hawaiian or Other Pacific Islander

**Primary Language**: ____________________

**Employment Status:** Full Time Part Time Retired Self Employed Unemployed

**Employer:** ______________________________ **Occupation:** ______________________________

**Insurance Name:** ________________________________________ **ID #** ____________________

**Subscriber Name:** ____________________ **Relation:** ____________________

**Secondary Insurance Name:** ____________________ **ID #** ____________________

**Subscriber Name:** ____________________ **Relation:** ____________________

**Emergency Contact Name:** ________________________________________

**Phone Number:** ____________________ **Relation:** ____________________

**Who referred you to Highgate Medical Group? Are any family members or friends currently under our care?**

________________________________________________________________________

________________________________________________________________________

**I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.**

**Patient (or responsible party) Signature:** ______________________________ **Date:** __________

## Patient Health History

**Name:** ____________________________________________ **Date:** ____________________
**SSN:** ______________________________________________ **DOB:** ____________________

**Chief Complaint: What is the reason for your visit today? (Please describe the problem in detail):**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Patient Medical History:** Please check all that apply to you

☐ Asthma/COPD ☐ Depression/Anxiety ☐ Hypertension ☐ Thyroid disease
☐ Autoimmune Disease ☐ Diabetes ☐ Kidney disease ☐ Other ___________________________
☐ Arthritis ☐ Gastrointestinal disease ☐ Sleep apnea ☐ None
☐ Cancer ☐ Heart disease ☐ Stroke

**Please describe:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Previous Surgeries:** Please list any surgeries with approximate date

______________________________________________________________________________
______________________________________________________________________________

**Serious Injury:** Please describe any previous serious injuries (i.e. car accident, fractured bones)

______________________________________________________________________________
______________________________________________________________________________

**Medications:** Please list any medications including the dose and frequency. (there is additional space on the next page)

| ***Drug*** | ***Dose/Frequency*** |
| --- | --- |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |

**Allergies:** please list any allergies that you have including reaction

______________________________________________________________________________
______________________________________________________________________________

**Social History:**

Do you drink alcohol? ☐ **YES** ☐ **NO** If yes, how much/week? ______________________________
Do you smoke? ☐ **YES** ☐ **NO** If yes, how many cigarettes per day? ____________________
Do you consume caffeine? ☐ **YES** ☐ **NO** If yes, how many cups per week? _______________________
Do you use recreation drugs? ☐ **YES** ☐ **NO** If yes, what type/frequency? ___________________________
Are you on a special diet? ☐ **YES** ☐ **NO** If yes, please describe? _______________________________

**Family History:** Do you know of any blood relative who has or had:

☐ Asthma ☐ Diabetes ☐ Mental health disorder ☐ Thyroid
☐ Aneurysm ☐ Heart problems ☐ Multiple Sclerosis ☐ Other __________________
☐ Autoimmune disease ☐ High blood pressure ☐ Psychiatric disease ☐ None
☐ Cancer ☐ Kidney disease ☐ Stroke

**Please describe (include condition and family member):**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Additional History

*Please use the extra space below to provide any additional information from above*

**For further information regarding completion of your Health Care Proxy please visit:**
**https://health.ny.gov/**

# Patient Health History

Please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section, please check none.

**GENERAL HEALTH**
- ☐ Recent weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Fever/Chills

**EARS, NOSE, MOUTH, THROAT**
- ☐ Difficulty swallowing
- ☐ Earaches
- ☐ Loss of hearing/deafness
- ☐ Painful chewing
- ☐ Ringing in ears
- ☐ Sinus infection
- ☐ Sores in mouth
- ☐ Other ______________________
- ☐ None

**EYES**
- ☐ Blind Spots
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Glaucoma
- ☐ Injury
- ☐ Pain
- ☐ Other ______________________
- ☐ None

**GASTROINTESTINAL**
- ☐ Blood in stools
- ☐ Increasing constipation
- ☐ Nausea
- ☐ Painful bowel movements
- ☐ Persistent diarrhea
- ☐ Stomach or abdominal pain
- ☐ Ulcer
- ☐ Vomiting
- ☐ Other ______________________
- ☐ None

**CARDIOVASCULAR**
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other ________________________
- ☐ None

**GENITOURINARY**
- ☐ Blood in urine
- ☐ Female: irregular periods
- ☐ Female: #pregnancies _____
  #miscarriages _____
- ☐ Male: prostate disease
- ☐ Male: testicle pain
- ☐ Kidney stones
- ☐ Painful or burning urination
- ☐ Sexual difficulty
- ☐ Sexually transmitted disease
- ☐ Urgency with urination
- ☐ Urine retention/incontinence
- ☐ Other ______________________
- ☐ None

**MUSCLES/JOINT/BONES**
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain or tenderness
- ☐ Neck pain
- ☐ Other ______________________
- ☐ None

**PULMONARY**
- ☐ Asthma
- ☐ Blood in cough
- ☐ Chronic or frequent cough
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Other________________________
- ☐ None

**PSYCHIATRIC**
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Eating disorder
- ☐ Other ______________________
- ☐ None

**NEUROLOGICAL**
- ☐ Balance trouble
- ☐ Difficulty speaking
- ☐ Difficulty walking
- ☐ Facial drooping
- ☐ Fainting
- ☐ Headaches/migraines
- ☐ Injury to the brain/spine
- ☐ Lightheaded or dizziness
- ☐ Memory loss
- ☐ Ministroke/TIA
- ☐ Neuropathy
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremors
- ☐ Weakness
- ☐ Other ______________________
- ☐ None

Are you? ☐ right-handed ☐ left-handed ☐ both

**SKIN**
- ☐ Changing moles
- ☐ Hair loss
- ☐ Infections
- ☐ Rash or itching
- ☐ Other ______________________
- ☐ None

**SLEEP**
- ☐ Snoring
- ☐ Sleep walking
- ☐ Nightmares

Do you sleep well? ☐ Yes ☐ No

Do you feel rested when you wake? ☐ Yes ☐ No

Do you fall asleep during the day? ☐ Yes ☐ No

**Highgate Medical Group, P.C.**
**Patient Financial Policy**

Thank you for choosing Highgate Medical Group, P.C. as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policy, and your responsibilities. To prevent any billing delays or difficulties, the office must be notified of any patient information changes. (i.e., address, name, insurance information, phone number, etc.)

**Insurance Claims**

All services will be billed to responsible companies. If for any reason the claim is rejected, you will be responsible for payment. Payment is due upon receipt. A service charge of $10 will be applied after the first statement to your account if the balance is not paid in full within 30 days.

**Co-pays**

All copays are due at the time of check in. Otherwise, your appointment needs to be rescheduled.

**Self-Pay Accounts**

Self-pay accounts are payments without insurance coverage, or patients covered by insurance plans in which the office does not participate. Self-pay patient's will be required to pay for services at the time of their visit, where an estimate of cost will be presented.

**Missed appointments & Same day cancelations**

If you are a **new patient,** we require 48-hour cancelation notice to your scheduled appointment. Highgate Medical Group requires a 24-hour cancelation notice prior to your scheduled appointments. There is a $40 "no show" and "same day" cancelation fee. Repeated missed appointments may result in dismissal from the practice.

**Returned Checks**

The charge for a returned check is $25 payable by cash. This will be applied to your account in addition to the insufficient amount.

**Completion of Medical Forms**

There will be a $15 charge fee for the completion of ALL forms. (i.e., disability, school physicals, FMLA, etc.)
* This includes "just a signature"

**Outstanding Balance Policy**
It is our policy that all past due accounts will be sent 3 statements and a collection reminder letter. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. If no resolution can be made, the account will be sent to the collection agency and possible dismissal from the practice. Regardless of any personal arrangements that a patient might have outside our office, if you are over 18 years of age and receiving treatments, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. All costs associated with our collection efforts (including collection agency fee) will be passed on to you. This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

**Consent/Authorization for treatment and Release Information/Disclosure Personal Information**

I hereby agree that Highgate Medical Group, P.C. may perform care and treatment any may conduct such examinations, laboratory tests and procedures as directed by my physician or treatment practitioner.

I hereby consent to the use and disclosure of my Protected Health Information by Highgate Medical Group, P.C. for purposes of treatment, payment and health care operations. Any release of my medical records and Protected Helath Information may be made according to the state and federal regulations. I understand that Highgate Medical Group, P.C. may release medical information to any third party which may be responsible for payment of my medical expenses.

**I understand that I am financially responsible to Highgate Medical Group, P.C. for any balance not covered by the insurance carrier.**

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid to Highgate Medical Group, P.C.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

**Name:** ________________________________________________________________**Date:** _____________

**Signature:** ____________________________________________________________

# Health Care Proxy

**(1) I,** ____________________________________________

hereby appoint ____________________________________________
*(Name, home address and telephone number)*

____________________________________________

____________________________________________

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

**(2)Optional: Alternate Agent**
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint ____________________________________________
*(Name, home address and telephone number)*

____________________________________________

____________________________________________

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

**(3)** Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shallremain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: ____________________________________________

____________________________________________

____________________________________________

**(4) Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: ____________________________________________

____________________________________________

____________________________________________

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

**(5) Your Identification** *(please print)*

Your Name ______________________________

Your Signature ______________________________ Date ______________

Your Address ______________________________

**(6) Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues ______________________________

______________________________

☐ Limitations ______________________________

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature ______________________ Date ______________________

**(7) Statement by Witnesses** *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date ______________________ Date ______________________

Name of Witness 1
*(print)* ______________________

Name of Witness 2
*(print)* ______________________

Signature ______________________ Signature ______________________

Address ______________________ Address ______________________

We'd like to update your social history at today's visit!

*Please circle/fill in the answer to the following questions:*

Legal Marital Status: Single Married Divorced Widowed

Who lives with you: Spouse Alone Children Other?

If Other, explain: ____________________________________________________

Highest level of education:

8th grade High School Some college (how many years _______)

Associate's Bachelor's Master's Doctorate +

Occupation: Unemployed Retired Disabled

Employed (Title ______________________ Where______________________)

Alcohol Intake: None Occasional/Socially Regular use: # of drinks per day _______

Tobacco Use: Never

Former Tobacco User: (smoked how many packs a day for how long?) _________

Current Tobacco User: (how many packs a day for how long?) _______________

Other Tobacco Use: please specify_____________________________________

Illegal Drug Use: Never

Former User: (What did you use?) _______________________________

Current User: (What do you use?) ________________________________

Are you sexually active? Never Not currently Yes

Any family history of mental illness or substance abuse? No

If yes, please explain: _______________________________________________

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Choose an answer of **Not at all, several days, more than half the days or nearly every day.**

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| 2. Feeling down, depressed or hopeless | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling asleep or staying asleep or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| 4. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| 5. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| 8. 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 | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

| | Not difficult | Somewhat Difficult | Very Difficult | Extremely Difficult |
|---|---|---|---|---|
| 10. If you choose 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? | ☐ | ☐ | ☐ | ☐ |

---

**CAGE-AID QUESTIONNAIRE**

1. In the last three months, have you felt you should cut down or stop drinking or *using* drugs?

   ☐ YES ☐ NO

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using* drugs?

   ☐ YES ☐ NO

3. In the last three months, have you felt guilty or bad about how much you drink or *use* drugs?

   ☐ YES ☐ NO

4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use* drugs?

   ☐ YES ☐ NO

**General Anxiety Disorder GAD-7**

During the last 2 weeks, how often have you been bothered by the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge? | ☐ | ☐ | ☐ | ☐ |
| 2. Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| 3. Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| 4. Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| 5. Being so restless that it is hard to sit still | ☐ | ☐ | ☐ | ☐ |
| 6. Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| 7. Feeling afraid as if something awful might happen | ☐ | ☐ | ☐ | ☐ |

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 difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | Social Security Number |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released 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 1 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 ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9b**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (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

Authorization to Discuss Health Information

(b) ☐ By initialing here _______ I authorize ________________________________________
Initials Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:

__________________________________________________________

(Attorney/Finn Name or Governmental Agency Name)

| 10. Reason for release of information:<br>☐At request of individual<br>☐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.

________________________________________ Date: _________________________

Signature of patient or representative authorized by law.

* 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.