Facility: BELLEVUE HOSPITAL CENTER

(GENERAL CONSENT FOR TREATMENT)

FORM A

Read Only
Do Not Sign
BELLEVUE WORLD TRADE CENTER CLINIC

For patients seeking in-patient, out-patient and/or emergency room services.

1. I am asking for medical care and treatment at this facility and agree to accept services which may diagnose a medical condition, procedures to treat my condition and routine dental and medical care, including vaccination. I understand that these services will be provided to me by physicians, dentists, nurse practitioners, midwives, physician assistants and other health care providers, some of whom may be in training. I have not been given any guarantees as to the results of the services I will receive.

2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.

3. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures.

Signature of Patient or Parent/Legal Guardian of Minor Patient

Do Not Sign

If the patient cannot consent for themself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient’s surrogate who is consenting to the treatment for the patient, must be obtained.

Signature of Health Care Agent/Legal Guardian
(Place a copy of the authorizing document in the medical record)

Do Not Sign

Signature and Relation of Surrogate

WITNESS:

I am a staff member who is not the patient’s physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.
AS DESCRIBED IN THIS FORM, I HEREBY AUTHORIZE THE NYC HEALTH + HOSPITALS (THE “SYSTEM” OR “SYSTEM OPERATED FACILITIES”) TO USE, RECEIVE, AND DISCLOSE MY HEALTH INFORMATION AS THE SYSTEM DEEMS NECESSARY FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND TO ACCESS MY HEALTH INFORMATION THROUGH NY CARE INFORMATION GATEWAY, A HEALTH INFORMATION EXCHANGE (“HIE”), IN WHICH THE SYSTEM PARTICIPATES.

WHAT IS CONSIDERED HEALTH INFORMATION?
Health information includes all of my medical, personal, social, and financial information related to or concerning the examination, assessment or treatment of me for a health condition. Health information may include laboratory results, medications, diagnostic test results, discharge summaries, progress notes, billing records, information obtained by the System from other health care providers, injuries sustained if I was a victim of a crime, as well as sensitive health information such as information pertaining to the treatment for mental illnesses, developmental disabilities, HIV/AIDS, substance use, reproductive health, sexually transmitted diseases and other communicable diseases, and genetic testing (including predisposition genetic tests) (collectively “sensitive health information”). Note that substance use information may include diagnostic information, medications and dosages, lab tests, allergies, substance use history summaries, trauma history summaries, elements of a medical record, such as clinical notes and discharge summary, employment information, living situation and social supports, and claims/encounter data.

WHAT ARE HEALTH CARE PROVIDERS?
When used in this form, the term health care provider (“HP”) includes, without limitation, hospitals; nursing homes; physicians and physician practice groups; dentists; podiatrists; pharmacies; facilities (including federally assisted facilities) that provide treatment for mental illnesses, substance use disorder, and developmental disabilities; ambulatory care clinics; medical providers at correctional facilities; medical providers at health and human services organizations and community-based treatment organizations; diagnostic and treatment centers; home health agencies; outpatient rehabilitation facilities; hospices; all System-operated facilities and their respective extension and school-based clinics; and any other provider of medical or health services.

WHAT ARE THE NAMES OF THE SYSTEM-OPERATED FACILITIES?
Bellevue Hospital Center; Coney Island Hospital; Cumberland Diagnostic & Treatment Center (“D&T”); Dr. Susan Smith McKinney Nursing and Rehabilitation Center; East New York D&T; Elmhurst Hospital Center; Governor Health Care Services; Harlem Hospital Center; Jacobi Medical Center; NYC Health + Hospital/At Home; Kings County Hospital Center; Lincoln Medical and Mental Health Center; Metropolitan Hospital Center; Morrisania D&T; North Central Bronx Hospital; Queens Hospital Center; Sydenham D&T; Sea View Hospital Rehabilitation Center & Home; Segundo Ruiz Belvis D&T; and Woodhull Medical and Mental Health Center.

PURPOSE AND DESCRIPTION OF AUTHORIZATION FOR THE SYSTEM TO DISCLOSE INFORMATION:

1. FOR TREATMENT PURPOSES: UNLESS STATED OTHERWISE BELOW, I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION to HPs and other persons or entities within or outside of NYC Health + Hospitals, where such disclosure is necessary as part of a consultation or referral, to facilitate my transfer or discharge from a System facility to another health care facility, for discharge planning purposes, or for the management and coordination of my health care and related services. Additionally, I authorize HPs who are currently treating me, have treated me in the past, or who will treat me in the future, to disclose my health information to and/or within NYC Health + Hospitals. I also authorize NYC Health + Hospitals to disclose my health information to my family members and other individuals who are involved in my care. Unless I instruct otherwise, the information released to my family members and other individuals involved in my care shall be limited to that information relevant to their involvement in my care and shall not include sensitive health information.

2. FOR PAYMENT PURPOSES, UNLESS STATED OTHERWISE BELOW, I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION to governmental agencies, insurance carriers, health insurers, health maintenance organizations or other third party payers or their agents that may be financially liable for my hospitalization, treatment, or medical care. I also authorize the disclosure of my health information to other HPs to which I am financially liable for their medical or health services provided to me.

3. FOR HEALTH CARE OPERATIONAL PURPOSES, UNLESS STATED OTHERWISE, I AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION to contractors, agents, and other third parties that provide services or functions to or on behalf of a NYC Health + Hospitals facility such as, but not limited to, legal, actuarial, accounting, consulting, data aggregation, management information systems, and data processing services.
benefit management, practice management, training, repricing services and activities, and health information exchanges (see information on health information exchanges directly below) that perform record management functions, to the extent that the System deems such disclosure necessary to carry out its health care operations.

Any disclosure of my health information pursuant to this authorization, however, will be limited to the amount of information that is necessary to carry out the purpose of the disclosure.

WHAT ARE HEALTH INFORMATION EXCHANGES?
NYC Health + Hospitals may release my health information to health information exchanges as part of its operations. HIEs are the electronic transmission of health care-related data among HPs, health information organizations and government agencies. The purpose of such exchanges is to promote the appropriate and secure access and retrieval of a patient's health information to improve the cost, quality, safety, and speed of patient care. These services allow the System to exchange my health information electronically with other HPs who have treated me in the past, are presently treating me and/or who will treat me in the future. It is possible that HIEs providing services to the System may connect electronically with other HIEs to assist in the electronic exchange of my health information between the System and other HPs. Once my health information is disclosed to an HIE, it will not be released to other HPs unless I have provided written consent for such disclosure. However, if a medical emergency exists, NYC Health + Hospitals may release my health information to and through HIEs to other HPs as it deems necessary to respond to the medical emergency without my written consent. I understand that I may ask my treating provider or patient representative at the System for more information about HIEs.

PURPOSE AND DESCRIPTION OF AUTHORIZATION FOR THE SYSTEM TO ACCESS INFORMATION THROUGH HIEs
The System will use my health information that it accesses through HIEs only for the following health care purposes:

1) TREATMENT SERVICES. To provide me with medical treatment and related services.

2) INSURANCE ELIGIBILITY VERIFICATION. To check whether I have health insurance and what it covers.

3) CARE MANAGEMENT ACTIVITIES. These include assisting me in obtaining appropriate medical care, improving the quality of services provided to me, coordinating the provision of multiple health services provided to me, and supporting me in following a plan of medical care.

4) QUALITY IMPROVEMENT ACTIVITIES. To evaluate and improve the quality of medical care provided to me and all patients.

WHERE INFORMATION ABOUT ME THAT IS AVAILABLE THROUGH HIEs COMES FROM
Information about me that is available through HIEs comes from places that have provided me with medical care or health insurance. These may include HPs, health insurers, the Medicaid program, and other organizations that exchange health information electronically. I understand that I have a right to request and be provided a list of entities to which my health information has been disclosed. A complete, current list is available from NY Care Information Gateway. I can obtain an updated list at any time by checking NY Care Information Gateway’s website at www.NYCIH.org, or by calling 718-334-5844.

DISCLOSURE OF RECIPIENTS OF INFORMATION
I understand that, consistent with federal and state laws and regulations, upon my request, I must be provided with a list of individuals and entities to which my health care information has been disclosed.

RE-DISCLOSURE OF INFORMATION
Any organization(s) to which I have given consent to access information about me may re-disclose my health information, but only to the extent permitted by state and Federal laws and regulations. Substance use treatment related information, confidential HIV-related information, and mental health or developmental disability related information may only be accessed and may only be re-disclosed if accompanied by a statement regarding the prohibition of re-disclosure either without my specific written consent, or as permitted by law or regulation.

REVOCATION AND TERM OF AUTHORIZATION
I may revoke this authorization in writing at any time except to the extent that NYC Health + Hospitals or other lawful holder of my health information that is permitted to make the disclosure has relied on it. Unless revoked in writing, this authorization shall expire 3 years from the date of my signature below.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
By signing directly below, I, or my personal representative, authorize NYC Health + Hospitals and other HPs to use, receive, and disclose my health information as described in this form. I sign this authorization willingly and understand the nature of the authorization I am providing. I understand that nothing in this form restricts NYC Health + Hospitals from releasing my health information where it is otherwise authorized by state or Federal law to do so. I am aware that my consent does not oblige NYC
I authorize the release of my health information for Treatment, Payment, and Health Care Operational Purposes.

I do not authorize the release of my health information for Payment Purposes. I understand that by selecting this option, I will be responsible for all costs and payments for any health care treatment and services rendered to me.

I do not authorize the release of my health information to HIEs. I understand that by selecting this option that HPs who treat me in the future may not be able to access my health records and history from the System electronically. This includes situations where I am unable to communicate my health history to my HP because I can’t remember or as a result of a medical emergency.

I do not authorize the release of my health information to my Family Members or Other Individuals who are involved in my care without my additional written consent unless such individuals are authorized by law to make health care decisions on my behalf.

I understand that I may discuss any other disclosure restriction not listed above with my NYC Health + Hospitals Treating Provider or Patient Representative.

<table>
<thead>
<tr>
<th>Signature of Patient or Personal Representative</th>
<th>If not Patient, Name of Personal Representative Signing Form</th>
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<tr>
<td><strong>Do Not Sign</strong></td>
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Description of Personal Representative’s Authority to Act on Behalf of Patient

**Do Not Sign**

Internal Use Only

Originateing System Facility ___________________________ Additional Restrictions ___________________________
ACKNOWLEDGEMENT OF
PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES
AND PROXY, AND MEDICARE, MEDICAID, AND THIRD-PARTY PAYORS
RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

<table>
<thead>
<tr>
<th>PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES AND PROXY</th>
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<tbody>
<tr>
<td>I have received Patient' Bill of Rights and Responsibilities, Advance Directives and Proxy.</td>
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Do Not Sign
New York City Health and Hospitals Corporation
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The New York City Health and Hospitals Corporation ("NYCHHC") is required under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to provide you with a description of the types of information that we gather about you, with whom that information may be shared, the safeguards that we have in place to protect it, and your rights to access and amend your health information. Because this notice only describes your privacy protections and other rights related to your medical information under HIPAA, you may be afforded additional protections and rights under other federal laws and/or State law that are not described in this notice. If the practices described in this notice meet your expectations, there is nothing further you need to do. If you prefer that we not share certain information, you may make a written request, as described below. If you have any questions regarding this Privacy Notice, or a complaint about our privacy practices, please contact our Corporate Privacy Officer at CPO@NYCHHC.org or toll-free at 1-866-HELP-HHC.

Who Will Follow This Notice?

This notice describes NYCHHC's privacy practices and that of:

- Any health care professional authorized to enter information into your medical chart.
- All departments and units of NYCHHC, its hospitals, clinics, community providers, and affiliates working with NYCHHC to provide health care at NYCHHC facilities.
- Any member of the NYCHHC workforce including all employees, staff, volunteers, students, and other NYCHHC personnel.

All of these entities and facilities follow the terms of this notice. In addition, these individuals, entities, and locations may share medical information with each other for purposes of treatment, payment, health care operations, or research, as described in this notice.

A NYCHHC business associate may use or disclose your medical information only as permitted or required by its contract or other agreement with HHC. A NYCHHC business associate is not a member of the NYCHHC workforce, but has a relationship with NYCHHC to perform, or assist in the performance of, a function or activity on behalf of NYCHHC. A business associate

HHC Privacy Notice – Form 2376 (English)
for your health care services. For example, we may need to give your health plan information about surgery you received at NYCHHC so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. However, for services that you pay for out-of-pocket, and/or in full, you may request that we limit the information shared with your insurance company.

**For Health Care Operations.** We may use and disclose medical information about you as needed to run NYCHHC operations on a daily basis and to make sure that all of our patients receive quality care. For example, we may use medical information to review the quality of our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services NYCHHC should offer, what services are not needed, and whether certain new treatments are effective. When necessary, we may also disclose information to our accountants, consultants, and other professionals who help us operate the facility.

**Appointment Reminders.** We may use and disclose medical information to contact you with reminders that you have an appointment at the facility.

**Sale of Medical Information.** NYCHHC is generally prohibited from selling your medical information. However, in most circumstances or activities for which we expect to receive financial payment for disclosing medical information, we must obtain your written authorization before we use or disclose the information, if the payment that we receive is not related to a medical treatment or service that we have provided.

**Marketing.** We must obtain your written authorization before we use your medical information to communicate with you about purchasing or using a product or service, unless the communication is: made face-to face between you and NYCHHC or consists of a promotional gift of nominal value provided to you by NYCHHC. The following do not require prior authorization, unless NYCHHC receives payment from a third party in exchange for contacting you:

- **Drug Information.** We may use and disclose medical information to provide refill reminders or to provide information about a drug that you have been prescribed.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about treatment options that may interest you including case management or care coordination, alternative treatments, therapies, health care providers, or care settings.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits, products and services including NYCHHC owned health plans, and events that may interest you.

**Fundraising Activities.** We may use information, including your name, address, age, date of birth, gender, treating physician, dates of treatment, the department in which you received services, and certain other information unrelated to your condition, to contact you to raise money for our facilities and their health care operations. We may share that same information with an NYCHHC-related foundation or business associate for the same
**Workers' Compensation.** We may release medical information about you to your employer’s insurance carrier, to the Workers’ Compensation Board or to similar programs.

**Public Health Activities.** We may share medical information about you for public health purposes with government organizations that are authorized to prevent the spread of disease, or to receive reports of certain medical conditions, births, deaths, abuse, neglect, and domestic violence. We will try to obtain your permission before releasing this information, except when we are required or authorized to act without your permission.

**Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information.** Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, psychotherapy notes (under federal law), and genetic information. If your care involves these special areas, please contact your health care providers or counselors for more information about these additional protections.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, and inspections.

**Legal Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release your medical information for law enforcement purposes, including the following:

- To respond to legal proceedings
- To identify or locate a suspect, fugitive, material witness, or missing person
- In circumstances pertaining to victims of a crime
- In the case of deaths we believe may be the result of criminal conduct
- In the case of crimes occurring at the facility
- To report a crime in an emergency; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

**Death.** In the event of your death, NYCHHC may use and disclose your protected health information in order to notify or assist in locating your family member, next-of-kin, personal representative, or other person involved in your care about your death, unless doing so would be inconsistent with any prior preference or instruction that you have expressed in writing to NYCHHC. In making any such disclosure, NYCHHC personnel will ensure that only the protected health information that is relevant and necessary for notification or location purposes is used. Otherwise, NYCHHC may only disclose your protected health information to a surviving relative or
facility. All amendment requests must be in writing. To request an amendment, complete a NYCHHC Request for Amendment form or submit a written request to the facility's Health Information Management Department. You must provide a reason to support your request for amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless you provide us with a reason to believe that the person who created the information is no longer available to act on the amendment.
- Is not part of the information that may be used to make decisions about you.
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures that NYCHHC has made of medical information about you. The list will not include certain information, such as information we have shared for your treatment, payment, or NYCHHC health care operations, or those disclosures we have made with your permission. To request this list, please submit your request in writing to the facility's Health Information Management Department. Your request must include a time period that may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (i.e., on paper or electronic format). The first list you request within a 12-month period will be free. For additional lists, we may charge a reasonable cost-based fee to cover the cost of providing the information. We will notify you of the cost involved and you may choose to cancel or change your request at that time before you've been charged.

Right to Request Restrictions. You have the right to request a restriction on the medical information that we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information that we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a medical procedure that you had. To request restrictions, please complete a NYCHHC Request for Additional Privacy Protections form. You may also submit a written request to the facility's Director of Admitting or the Director of Registration. In your request, please tell us:

- What information you want to limit
- Whether you want to limit our use, disclosure or both
- To whom you want the limits to apply (for example, disclosures to your spouse)

We are not required to agree to your restriction request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, please submit your request in writing to the facility's Medical Correspondence Unit. We will not ask you the reason for your request. We will accommodate
Acknowledgement

By signing and dating the form below, I acknowledge that I have received a copy of the New York City Health and Hospitals Corporation's Privacy Notice.

Patient's Name

Patient's Medical Record Number

Patient's Signature

Do Not Sign

Date

If executed by a patient's personal representative, please print your name in the space below:

Personal Representative's Name

Personal Representative's Signature

FOR USE BY NYCHHC STAFF ONLY:

☐ Patient refused to sign
☐ Patient unable to sign

NYCHHC Employee's Initials

Today's Date
NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>PATIENT SSN</th>
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<th>MEDICAL RECORD NUMBER</th>
<th>TELEPHONE NUMBER</th>
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<th>NAME OF HEALTH PROVIDER TO RELEASE INFORMATION</th>
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<tr>
<td>Bellevue Hospital / WTC Clinic</td>
</tr>
<tr>
<td>462 First Ave-7 East T:(212) 562-1720</td>
</tr>
<tr>
<td>New York, NY 10016 F:(212) 562-1759</td>
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<th>SPECIFIC INFORMATION TO BE RELEASED:</th>
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<tr>
<td>Medical records, tests, labs, PFTs, x-rays, progress notes, WTC-3 reports &amp; Narrative for certification</td>
</tr>
<tr>
<td>Treatment Dates from Initial to Present</td>
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<tr>
<th>INFORMATION TO BE RELEASED (if the box is checked, you are authorizing the release of that type of information). Please note: unless all of the boxes are checked, we may be unable to process your request.</th>
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<tr>
<td>Alcohol and/or Substance Abuse Program Information</td>
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<tr>
<td>Genetic Testing Information</td>
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<tr>
<td>HIV/AIDS-related information</td>
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<th>WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)</th>
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<td>On this date</td>
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I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

I understand that if my medical and/or billing records contain information relating to ALCOHOL or SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH, and/or CONFIDENTIAL HIV/AIDS RELATED INFORMATION, this information will not be released to the person(s) I have indicated unless I check the box(es) for this information on this form.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-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.

I understand that I have a right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.

I understand that I have a right to request to inspect and/or receive a copy of the information described on this authorization form by completing a Request for Access Form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

To revoke this authorization, please contact the facility Health Information Management department processing this request.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accept all of the above.

<table>
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<tr>
<th>SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE</th>
<th>IF NOT PATIENT, PRINT NAME &amp; CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Do Not Sign</td>
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To the extent that NYCHHC has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage.

If HHC has requested this authorization, the patient or his/her Personal Representative must be provided a copy of this form after it has been signed.
INFORMED CONSENT FORM TO PARTICIPATE AND AUTHORIZATION FOR RESEARCH

TITLE OF RESEARCH REGISTRY:

NYU/Bellevue WTC Health Impacts Research Registry

A. PURPOSE OF THE RESEARCH REGISTRY:

Many advances in medicine have resulted from the study of information in the medical records of patients with a certain disease or condition. Because you are being seen as part of the World Trade Center Environmental Health Center, we are asking for your permission to allow us to place your past, current and future medical record information into a New York University/Bellevue World Trade Center Health Impacts Research Registry (NYU/Bellevue WTC Health Impacts Research Registry). Prior studies have suggested that exposure to WTC dust can be associated with new onset or worsening of some medical symptoms. By placing the medical record information of many patients such as you into a Research Registry, researchers will be able to conduct studies to increase knowledge about the health effects of exposure to World Trade Center dust. Dr. Joan Reibman will maintain the Research Registry and will only allow the Registry to be used for research as permitted by IBRA policies and federal regulations.

The Research Registry will assist our investigators in two important ways:

First, it will allow researchers to review and study the medical records of many individuals to answer questions about the nature and treatment of environmental exposures such as yours.

Second, it will help researchers identify and recruit patients who are eligible for participation in future research studies.

B. SUBJECT PARTICIPATION:

We estimate that the following number of subjects will enroll in this study:
At this site: 10000       Total at all sites: 14000

SUBJECT PARTICIPATION:

☐ Inpatient
☒ Outpatient
☒ other [healthy subjects, etc.] Please specify: Health subjects
As described above, certain identifiers (e.g., your name, social security number, and medical record number) will be removed from your health information before it is placed in the Research Registry. Information from the Registry will only be used or disclosed for research that meets the requirements of the IBRA and federal regulations; however, organizations or entities that oversee research, including federal and state regulatory agencies, and IRB(s) overseeing the research may receive your information, including identifiable information, if necessary to ensure that research meets legal and ethical requirements.

Researchers at this or other institutions may wish to study Registry information in future research. Before your information in the Research Registry may be used for a research project, all direct identifiers will be removed or the researcher must obtain approval from the IBRA.

Confidentiality of Your Medical Records

Your medical records will be maintained in accordance with state and federal laws concerning the privacy and confidentiality of medical information. The confidentiality of your medical record is protected by new federal privacy regulations, as described below.

Confidentiality of Your Study Information

This Registry will include information that may identify you, either directly or indirectly. We will try to keep this information confidential, but we cannot guarantee confidentiality. Researchers using Registry data will be required to remove any identifying information before publishing the results of their research.

Retention of Your Study Information

Information placed in the Research Registry will be kept there and used for research indefinitely.

Your HIPAA Authorization

A new federal regulation, the federal medical Privacy Rule, has taken effect as required by the Health Insurance Portability and Accountability Act (HIPAA). Under the Privacy Rule, in most cases we must seek your written permission to use or disclose identifiable health information about you that we use or create [your "protected health information"] in connection with research involving your treatment or medical records. This permission is called an Authorization.

If you sign this form you are giving your Authorization for the uses and sharing of your protected health information as described in this Consent/Authorization form. You have a right to refuse to sign this form. If you do not sign the form your information will not be placed in the Research Registry, but refusing to sign will not affect your health care, participation in the NYU/Bellevue WTC Health Impacts Research Registry, or payment for your health care.

This Authorization will not expire unless you revoke it in writing. You have the right to revoke your Authorization at any time, except to the extent that NYU/Bellevue has already relied upon to disclose data to the Research Registry. The procedure for revoking your authorization is described below in Section H.
or revoke your Authorization we will not continue to place your health information in the research registry. There is no penalty for withdrawing your consent and revoking Authorization; however, you may not withdraw consent or revoke your Authorization for uses and disclosures that we have already made or must make to complete analyses or report data for Registry research already in progress.

To formally withdraw your permission for participation in the NYU/Bellevue WTC Health Impacts Research Registry and/or your Authorization for use and disclosure of your protected health information you should provide a written and dated notice of this decision to the principal investigator of the Research Registry at the address listed below.
Joan Reibman, MD
Department of Medicine
NYU Medical Center
550 First Ave.
New York, NY 10016

I. CONTACT PERSON(S):

For further information about your rights as a research subject, or if you are not satisfied with the manner in which this study is being conducted and would like to discuss your participation with an institutional representative who is not part of this study, please contact the Administrator, Institutional Board of Research Associates, Telephone No. 212-263-4110.

If you have any questions or feel that there has been a breach of privacy or confidentiality associated with the your participation in the Research Registry, please contact the Principal Investigator Joan Reibman, MD at the following telephone number (212) 562-3704.

AGREEMENT TO PARTICIPATE AND AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Part of the consent process includes your Authorization to use Protected Health Information for the purposes of this Research Registry, as described above. If you do not want to authorize the use of this PHI, you should not sign this form

☐ I have read this consent/Authorization form
or
☐ it was read to me by: ________________________.

Any questions I had were answered by: ____________________.

I ☐ am ☐ am not participating in another research registry at this time.
(If yes, you should discuss this with your study doctor.)

I voluntarily agree to participate in the Research Registry to be created and maintained at:
H#: 06-1
Consent Version Date: 12/17/2018
Office of Institutional Board of Research Associates NYU School of Medicine

Print Name of Participant or Legal Representative*  Signature of Participant or Legal Representative* /

[Do Not Sign]

Print Name of Person Obtaining Consent  Signature of Person Obtaining Consent  Date

[Use this section only when a witness is required.]

** When the elements of this form are presented orally to the subject or representative, a witness to the oral presentation is required. Even when the form is presented orally, either the subject or the personal representative must sign the form.

Print Name of Witness**  Signature of Witness**  Date

WHEN THE SUBJECT IS A CHILD: ASSENT FORM

My parent/guardian knows about this study and wants me to be in the study if I want to. I do want to be in the study, but I know that I can stop being in the study any time I want to. I know that my study doctor can talk about the study with my parent/guardian, but will not talk about it with anyone else who is not working on the study unless I and my parent/guardian say it is OK. I can call the study doctor any time I have any questions.

Signature of Child  Date

☐ I have solicited the assent of the child [Do Not Sign]

Signature of Person Obtaining Assent/Consent  Date

Consent of Parent or Guardian:

☐ I agree with the manner in which assent was solicited and given by my child and I agree to have my child participate in the study.

☐ Although my child did or could not give his/her assent, I agree to have my child participate in the study.

☐ I will be given a signed copy of this Consent Form.