NYC HEALTH + HOSPITALS | Gotham Health

165 VANDERBILT AVE STATEN ISLAND NY 10304

# NEW PATIENT REGISTRATION FORM

| **Patient Information** | | **Date** | | MRN | |
|---|---|---|---|---|---|
| **Name (Legal Last,First,MI** | | | **Email Address** | | |
| **Street Address/Mailing Address** | | | **City** | **State** | **Zip Code** |
| **Home Phone** ( ) | **Cell Phone** ( ) | **Work Phone** | **Mother's Maiden Name** | | **Religion** |
| **Social Security Number** | **Date of Birth** | | Gender ( Circle One ) **Male** **Female** **Other** | | |
| **Race** | **Ethnicity** | Martial Status (**Circle One** ) Single Divorced Life Partner Married Widowed Separated | | Preferred Language | |
| Employment Status ( Circle One ) Full Time Part Time Not Employed Student Retired Other | | | | | |

| **Guarantor** | **Employer** | | | **Phone(** ) | |
|---|---|---|---|---|---|
| **Name (Legal Last,First,MI)** | | Realationship to Patient | | Email Address | |
| **Street Address/Mailing Address** | | | City | State | Zip Code |
| **Home Phone** ( ) | Cell Phone ( ) | | Employment Status: Full Time Part Time | | |
| Social Security Number | Date of Birth | | Gender ( Circle One ) Male Female | | |

**Emergency Contact**

| **Name ( Legal Last,First )** | | **Street Address** | **Relationship to Patient** |
|---|---|---|---|
| Home Phone ( ) | **Cell Phone** ( ) | Email Address | |

**Insurance Information**

| **Primary Insurance** | | **Policy Number** | | Group Number | |
|---|---|---|---|---|---|
| Patient's Relationship to Insured ( **Circle One )** Self Spouse Child Other__________ | | | Name of Subscriber **( if other than patient )** | | |
| Subcriber's Social Security Number | Date of Birth | | Employer of Subcriber | | Work Number |
| Employment Status ( Circle One ) Full Time Part Time Not Employed Student Retired Other | | | | | |

**PCP Information**

| Primary Care Physician's Name | **Office Number** ( ) | Fax Number ( ) |
|---|---|---|

Chart No.

Name

Ward No.

*(Patient Imprint Card)*

**NEW YORK CITY**
**HEALTH AND HOSPITALS CORPORATION**

# GENERAL CONSENT FOR TREATMENT

## FORM A

***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. 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.

X ______________________________ ______________
**Signature of Patient or Parent/Legal Guardian of Minor Patient** **Date**

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If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's next of kin who is assenting to the treatment for the patient, must be obtained.

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

______________________________ ______________
**Signature & Relation of Next of Kin** **Date**

**WITNESS:**

I, ______________________________ am a facility employee 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.

______________________________
**Signature and Title of Witness**

**INTERPRETER/TRANSLATOR:**
(To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

______________________________
**Signature of Interpreter/Translator**

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

# New York City Health and Hospitals Corporation (HHC)
## Consent to Release Health Information through the Interboro RHIO

| NAME AND/OR GENERAL DESIGNATION OF HEALTH CARE PROVIDERS AUTHORIZED TO RELEASE YOUR HEALTH-RELATED INFORMATION THROUGH THE INTERBORO RHIO. The form authorizes the general designation of Healthcare Providers described in section 3 on the back of this form and the Healthcare Providers listed in the attached document titled "Information Sources" **(collectively "RELEASING HPS") to disclose my health information through the Interboro RHIO.** The list of Information Sources may change from time to time, and in addition to listing the current Releasing HPs, the list provides you with instructions on how to obtain an updated list of Releasing HPs at any time. | PATIENT NAME<br><br>ADDRESS<br><br>DOB/MR# |
|---|---|
| NAME/ADDRESS OF HEALTHCARE PROVIDER(S) AUTHORIZED TO RECEIVE YOUR HEALTH-RELATED INFORMATION THROUGH INTERBORO RHIO ("ACCESSING HP") | |

<u>PURPOSE OF CONSENT FORM</u>. This form allows you to decide whether Releasing HPs may release your health-related information through the Interboro Regional Health Information Organization ("Interboro RHIO") as described in this form. The Interboro RHIO is a not-for-profit health information exchange (HIE). HIEs assist in the electronic sharing of health-related information among healthcare providers ("HPs") that have patients in common. HPs use the Interboro RHIO to release health-related information about their patients to other HPs that treat the same patients. HPs also use Interboro RHIO to access health-related information from other HPs and health information sources with which they have patients in common. Using the Interboro RHIO to release and access your health-related information can make it easier for HPs to provide you with safe and effective care. This kind of sharing is called health information technology or e-health. To learn more about e-health in New York State, you may read the brochure, "Better Information Means Better Care." You can either ask your provider for this brochure, or visit the website **www.ehealth4ny.org** to obtain it.

<u>DESCRIPTION OF CONSENT OPTIONS.</u> There are two consent options below. If you choose the **"I GIVE CONSENT"** option, you are saying "YES, I **want Releasing HPs to release all of my health-related information electronically to the Accessing HP listed above through the Interboro RHIO** as described in this form. If you choose the **"I DENY CONSENT"** option, you are saying **"NO, I do not want Releasing HPs to release my health-related information** electronically to **the Accessing HP listed above through the Interboro RHIO** as described in this form, **even if a medical emergency exists."** Your consent is completely voluntary. Your access to healthcare and treatment will not be affected because you gave your consent or did not give your consent on this form. This form can be filled out now or at a later date. Please read the front and back of this form, including any attachments, carefully and consider your choices. Remember, if you elect to fill out this form, you have two choices only.

<u>CONSENT CHOICES *(choose one only)*.</u>

☐ I GIVE CONSENT **for Releasing HPs to release** ALL **of my health-related information** electronically to **the Accessing HP** through the Interboro RHIO in connection with providing me any healthcare services, INCLUDING EMERGENCY CARE. Please note: This consent does not guarantee or mandate that all of your information will be released through the Interboro RHIO to accessing HPs.

☐ I DENY CONSENT **for Releasing HPs to release** ANY of my health-related information electronically to the Accessing HP through the Interboro RHIO for any purpose, **EVEN IN A MEDICAL EMERGENCY.** Please note: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to access your medical records, including records that are available through Interboro RHIO.

<u>WITHDRAWAL OF CONSENT</u>. If you give consent through this form, but later decide that you wish to withdraw your consent, you may do so at any time. There are two ways to withdraw your consent. One, at any time you can sign a **Withdrawal of Consent Form** and return it to the HHC Facility where you signed this form. Two, you can also change your consent choices by filling out and signing a new **RHIO Consent Form** at any time.

**You can get these forms on the** HHC **website at www.nychhc.org/HIE, or by calling 1-866-HELP-HHC. Please note:** to the extent permitted by this form and applicable state and federal law, HPs and other information sources may release, access, copy and/or include your health-related information in their own medical records while this consent remains in effect. Even if you later decide to withdraw your consent, HPs are not required to remove your information from their records.

<u>TERM OF CONSENT</u>. Unless you withdraw it, your consent will terminate ten (10) years from the date of your signature below or when the Interboro RHIO stops operating or six (6) months after your death, whichever comes first.

Signature of Patient or Patient's Legal Representative _______________ Date _______________

Print Name of Legal Representative (if applicable) _______________ Relationship of Legal Representative to Patient (if applicable) _______________

HHC-2777 (Jun 11)

**AUTHORIZATION TO USE, RECEIVE, AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS**

**Internal Use Only**

**Patient Name:** ______________________

**DOB:** ___/___/___

**Medical Record Number:** ______________________

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; Coler Rehabilitation and Nursing Care Center; Henry J. Carter Specialty Hospital and Nursing Facility; Coney Island Hospital; Cumberland Diagnostic & Treatment Center ("D&TC"); Dr. Susan Smith McKinney Nursing and Rehabilitation Center; East New York D&TC; Elmhurst Hospital Center; Gouverneur 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&TC; North Central Bronx Hospital; Queens Hospital Center; Sydenham D&TC; Sea View Hospital Rehabilitation Center & Home; Segundo Ruiz Belvis D&TC; 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 reimbursers 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, administrative, accreditation, financial, claims processing or administration, data analysis, insurance, risk management, compliance, processing or administration, medical records management and operations, laboratory analyses, utilization review, quality assurance, billing, 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.NYCIG.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) 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 obligate NYC Health + Hospitals to make any disclosures as described in this form. ***I understand that the choice I make on this form will NOT affect my ability to get medical care. I understand that I may restrict the disclosure of my health information for purposes of payment, or to HIEs and family members***, by indicating below (please check all that apply):

**Patient Name:** ____________________ **MRN:** ____________________

**BY SIGNING, 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 to HIEs. I understand that by selecting this option, 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 UNDERSTAND THAT I MAY DISCUSS ANY OTHER DISCLOSURE RESTRICTION NOT LISTED ABOVE WITH MY NYC HEALTH + HOSPITALS TREATING PROVIDER OR PATIENT REPRESENTATIVE.***

| **Signature of Patient or Personal Representative** | **If not Patient, Name of Personal Representative Signing Form** |
|---|---|
| X____________________ | ____________________ |
| **Date** ___/___/20___ | **Description of Personal Representative's Authority to Act on Behalf of Patient** ____________________ |

**Internal Use Only**

**Originating System Facility:** ______________ **Additional Restrictions:** ______________

## 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 ______________________ 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 ______________________