Office of Institutional Board of Research Associates
NYU School of Medicine
550 First Ave. Building #VET
10 West
NY, NY 10016
Phone: 212.263.4110
Fax: 212.263.4147

Principal Investigator: Joan Reibman. MD

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

We will continue to place your medical record information into the NYU/Bellevue WTC Health Impacts Research Registry until 1) you are no longer living; 2) you withdraw your permission for participation in the Research Registry; or 3) you revoke your HIPAA Authorization (described below).

Your medical record information contained within the NYU/Bellevue WTC Health Impacts Research Registry will be used and disclosed for research purposes for an indefinite period of time.

C. COSTS/REIMBURSEMENTS:

You will not receive any payment for participating in this Research Registry. If new products or treatments are developed from research using Registry information, you will not benefit financially.

D. POTENTIAL RISKS AND DISCOMFORTS/COMPENSATION FOR INJURY:

There are no risks of physical injury associated with your participation in the NYU/Bellevue WTC Health Impacts Research Registry. Participation in this Research Registry does involve the possible risk that information about your health might become known to individuals outside of the World Trade Center Environmental Health Center.

We will attempt to preserve your confidentiality by assigning a special research code number to your medical record information stored in the Research Registry, and by removing personal identifiers (for example, your name, social security number, medical record number) from information stored in the Research Registry. Information linking the Registry code number to your name and these personal identifiers will be stored in a separate secure location.

E. POTENTIAL BENEFITS:

It is unlikely that you will receive any direct benefit as a result of your participation in the NYU/Bellevue WTC Health Impacts Research Registry.

However, medical record information contained within the Research Registry will be used for research studies directed at improving our knowledge and treatment of the health effects of exposure to WTC dust and this knowledge may benefit patients with similar conditions in the future.

F. CONFIDENTIALITY:

Private information that could identify you will be used and shared to create the Research Registry and to provide Registry data to researchers. This section of the consent/authorization form describes how your information will be used and shared and the ways in which NYU School of Medicine will safeguard your privacy and confidentiality.

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.

By signing this form you authorize the use and disclosure of the following information to the Research Registry:

- Your medical records
- Results of laboratory tests performed in connection with your treatment at an NYU/Bellevue site or affiliated facility

By signing this form you authorize the following persons and organizations to use or disclose information to create and maintain the Research Registry

- Every NYU/Bellevue site or affiliated facility where you have received treatment or participated in research, including this hospital, and including each sites' research staff and medical staff
- Every NYUSM or Bellevue Hospital health care provider or affiliated provider who provides services to you
- Any laboratories and other individuals and organizations that analyze your health information in connection with your treatment or research participation at NYU/Bellevue Hospital or an NYU affiliate
- The members and staff of the site's affiliated Institutional Review Board
- The members and staff of the site's affiliated Privacy Board
- Principal Investigator: Joan Reibman, MD
- Research Coordinator
- Members of the Principal Investigator's Research Team
- The Patient Advocate or Research Ombudsman (GCRC)

Please be aware that once your protected health information is disclosed to a person or organization that is not covered by the federal medical Privacy Rule, the information is no longer protected by the Privacy Rule and may be subject to re-disclosure by the recipient.

G. VOLUNTARY PARTICIPATION AND AUTHORIZATION:

Your participation in this Research Registry and your Authorization for the use and disclosure of your protected health information are completely voluntary (of your free will). If you decide not to participate, it will not affect the care you receive or your ability to be treated in the World Trade Center Environmental Health Center. It will not result in any loss of benefits to which you are otherwise entitled.

You will be told of any significant new findings developed during the course of the Registry's use that may influence your willingness to continue to participate in the Registry.

H. WITHDRAWAL FROM THE STUDY AND/OR WITHDRAWAL OF AUTHORIZATION:

You may withdraw your consent for participation in the NYU/Bellevue WTC Health Impacts Research Registry at any time. You may also revoke your Authorization for your protected health information to be used or disclosed for the registry. If you either withdraw your consent

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:

☒Bellevue Hospital Center: this form and your study information will be available to Bellevue Hospital administration and their auditors.

I understand that I am entitled to and will be given a copy of this signed Consent/Authorization Form.

By signing this Consent/Authorization form, I give my Authorization for the uses and disclosures of my protected health information as described above.

J. PERMISSION TO CONTACT YOU ABOUT FUTURE RESEARCH:

I authorize the principal investigator and his or her co-investigators to contact me about future research provided that this future research is approved by the original IRB of record and that the principal investigator and co-investigator are affiliated with the research protocol. If I agree, then someone from Dr. Reibman's research staff might contact me in the future and he or she will tell me about a research study. At that time, I can decide whether or not I am interested in participating in a particular study. I will then have the opportunity to contact the researcher to schedule an appointment to be fully informed about the research project.

☐ I agree to be contacted by the Principal Investigator or Co-Investigators for future research studies.
☐ I **do not** want to be contacted by the Principal Investigator or Co-Investigator of the research studies.

_____

Signature of participant or legal representative Date

Your permission to allow us to contact you about future research would be greatly appreciated, but it is completely voluntary. If you choose not to allow us to contact you, it will not affect your care *[or your child's care]* at any of the NYUSM/Bellevue facilities. Please understand that giving your permission to do this is only for the purpose of helping us identify subjects who may qualify for one of our future research studies. It does not mean that you *[your child]* must join in any study.

K. WHEN THE SUBJECT IS AN ADULT:

* For subjects who may not be capable of providing informed consent, the signature of a legal representative is required. For a valid HIPAA authorization, the "personal representative" must have authority under state law to make health care decisions for the subject.

_____	_____/_____
Print Name of Participant or Legal Representative*	Signature of Participant or Legal Representative* Date
_____	_____/_____
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.

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.

Print Name of Parent(s)	*Date*
Signature of Parent(s)	*Date*
Print Name of Legal	*Date*
Signature of Legal Representative	*Date*

NYC HEALTH+ HOSPITALS

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

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES AND PROXY
I have received Patient' Bill of Rights and Responsibilities, Advance Directives and Proxy.
_____

Facility: **Bellevue Hospital Center**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Chart No.

Name

Unit

(Patient Imprint Card)

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, 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.

_____ _____ **and** _____ **am**
Signature of Patient or Parent/Legal Guardian of Minor Patient **Date** **Time** **pm**

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 surrogate who is consenting to the treatment for the patient, must be obtained.

_____ _____ **and** _____ **am**
Signature of Health Care Agent/Legal Guardian **Date** **Time** **pm**
(Place a copy of the authorizing document in the medical record)

_____ _____ **and** _____ **am**
Signature and Relation of Surrogate **Date** **Time** **pm**

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.

_____ _____ **and** _____ **am**
Signature and Title of Witness **Date** **Time** **pm**

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.

_____ _____ **and** _____ **am**
Signature of Interpreter/Translator **Date** **Time** **pm**

Effective date: September 23, 2013

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

may not use or disclose your health information in any way that NYCHHC could not use or disclose it.

Our Pledge Regarding Your Medical Information

We understand that information about you and your health is personal. We are thus committed to protecting the confidentiality of your medical information. As part of our routine operations, we create a record of the medical care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by NYCHHC, whether made by your personal doctor or other NYCHHC personnel.

Whenever we use the term "medical information" in this notice, we mean information created or received by NYCHHC about you that concerns your health care and payment for that health care. This notice tells you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Federal law requires us to:

- Maintain the privacy of your medical information
- Provide you with notice of our duties and privacy practices related to your medical information
- Notify you when there is a breach, or unlawful access, use, or disclosure of your information.
- Follow the terms of this privacy notice.

How We May Use and Disclose Your Medical Information

The following describes different ways that we may use and disclose your medical information. For each category of uses or disclosures we will explain what the category means and give examples. These examples are not exhaustive;

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at NYCHHC. For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the facility also may share medical information about you to coordinate the different things you need, such as prescriptions, lab work, and x-rays. When necessary, we may also disclose medical information about you to people outside the facility who may be involved in your medical care.

For Payment. Your protected health information will be used, as needed, to obtain payment

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

purposes. ***Opting Out of Fundraising Contacts.*** You may complete a *NYCHHC Request for Additional Privacy Protections* form or submit a written request to the facility's Director of Admitting or Director of Registration to "opt out" of being contacted for NYCHHC fundraising efforts. You cannot be denied treatment, or any other benefit or service for choosing not to receive fundraising contact.

Facility Directory. Unless you object, we may include certain limited information about you in the inpatient directory while you are hospitalized. This information may include your name, location in the facility, your general condition (e.g., fair, stable, etc.), and your religious affiliation. All of this information, except for your religious affiliation, may also be released to people who ask for you by name. Only members of the clergy will be told your religious affiliation. If you would prefer that NYCHHC not include some or all of this information in the facility directory, please notify the facility's Director of Admitting.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may release medical information about you to a friend or member of your family who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the facility. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Individuals Who May Act on Your Behalf. We may release medical information about you to a personal representative, parent, or guardian. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors, unless the minors are permitted by law to act on their own behalf.

Research. If you participate in a clinical trial, we will ask for your written permission before using or sharing your medical information. In certain circumstances, we may use your information without your written permission for a research study after a special approval process that ensures minimal risk to your privacy. Under no circumstances will a researcher reveal your name or identity publicly in preparation for, during, or after a research study.

As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you, when necessary, to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Disclosure Situations

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

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

legal representative, if they have legal authority to act on your behalf or present a valid authorization or court order.

Coroners, Medical Examiners, Funeral Directors, and Organ Donations. We may release your medical information to a coroner or medical examiner. We may also release medical information about patients of the facility to funeral directors, as necessary, to carry out their duties. Medical information may be used and disclosed for organ, eye, and tissue donations.

Disaster Relief. We may release or disclose your medical information to a public or private entity authorized by law or other authority to assist in disaster relief efforts, for the purpose of coordinating with such entity notifications to your family members, personal representative, or other person(s) responsible for your care of your location, general condition, or death.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, foreign heads of state, or to conduct special investigations.

Inmates. We may release medical information about inmates of a correctional institution to the correctional institution or law enforcement officials. This release would be necessary (1) for the institution to provide the inmate with health care; (2) to protect the inmate's health and safety or the health and safety of others; and (3) for the safety and security of the correctional institution.

Your Rights Regarding Your Medical Information

You have the following rights regarding medical information we maintain about you:

Right to Access and Copy. You have the right to request access to, and obtain a copy of, information that may be used to make decisions about you. This information includes medical and billing records, but does not include psychotherapy notes or information pertaining to an ongoing clinical trial. You have the right to request that copies of electronic records be provided in electronic form. To access and copy information that may be used to make decisions about you, please submit your request in writing to the facility's Health Information Management Department.

If you request that a copy of the information be provided to you, we may charge a fee to cover the costs of copying, preparing, and mailing the request. If you are denied access to information, we will provide you with a written explanation. You may request that the denial be reviewed. Another licensed health care professional chosen by NYCHHC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may request that we amend it for as long as the information is kept by or for the

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

all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Notice in the Event of a Breach. You have the right to be notified when your health information has been acquired, accessed, used or disclosed in a manner that is not legally permitted, and where NYCHHC determines that your health information has been compromised. You will generally be notified of a breach in writing, within 60 days of the event. You can contact Patient Relations, NYCHHC's Corporate Privacy Officer at CPO@NYCHHC.org, or call 1-866-HELP-HHC if you believe that your medical information has been improperly accessed, used or disclosed.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have obtained your Notice electronically, you are still entitled to a paper copy of this Notice. You may also obtain a copy of this notice at our website, www.nyc.gov/hhc. To obtain a paper copy of this notice, please request one from the facility's Admitting or Registration Department.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the facility. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, or have concerns about NYCHHC's privacy practices, you may file a complaint with NYCHHC or with the Secretary of the Department of Health and Human Services. To file a complaint with NYCHHC please call the toll-free Complaint Hotline at 1-866-HELP-HHC or send an email to CPO@NYCHHC.org. ***You will not be penalized for filing a complaint.***

Other Uses and Disclosures of Medical Information

Other uses and disclosures of medical information that are not covered by this notice, or by applicable federal, state, and local laws, will only be made with your written permission. If you provide us with permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures that we have already made with your permission and that we are required to retain in our records of the care that we provided to you.

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

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION

SPECIFIC INFORMATION TO BE RELEASED:

Information Requested: Medical notes, pathology reports, treatment plan, test labs, x-rays, CT scans

Treatment Dates from: Initial to: Present

NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT

Bellevue Hospital Center/ WTC Clinic
462 First Avenue 27th Street
New York, NY 10016

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.**

- [X] Alcohol and/or Substance Abuse Program Information
- [X] Mental Health Information
- [X] Genetic Testing Information
- [X] HIV/AIDS-related Information

REASON FOR RELEASE OF INFORMATION

- [ ] Legal Matter
- [ ] Individual's Request
- [X] Other (please specify): Continuity of care/ coordination of services

WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)

- [X] Event: Upon discharge BHC-WTC
- [ ] On this date: _____

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.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

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.

HHC USE ONLY

Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments:

NYC HEALTH+ HOSPITALS

Internal Use Only

Patient Name:

DOB:

Medical Record Number:

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

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 oradministration, 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, buy 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 the choice I make on this form will NOT affect my ability to get medical Care,* by indicating below (please check all that apply):

[ ] 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.

Signature of Patient or Personal Representative	**If not Patient, Name of Personal Representative Signing Form**

Description of Personal Representative's Authority to Act on Behalf of Patient

Internal Use Only

Originating System Facility _____ Additional Restrictions _____

WTC-3 HIPAA

NYCHHC HIPAA Authorization to Disclose Health Information

ALL FIELDS MUST BE COMPLETED

THIS FORM MAY NOT BE USED FOR RESEARCH OR MARKETING, FUNDRAISING OR PUBLIC RELATIONS AUTHORIZATIONS

PATIENT NAME/ADDRESS	DATE OF BIRTH	PATIENT SSN
	MEDICAL RECORD NUMBER	TELEPHONE NUMBER

NAME OF HEALTH PROVIDER TO RELEASE INFORMATION

Bellevue Hospital / WTC Clinic

462 First Ave-7East T:(212) 562-1720

New York, NY 10016 F:(212) 562-1759

SPECIFIC INFORMATION TO BE RELEASED:

Information Requested Medical records,tests,labs,PFTs,x-rays,progress notes, WTC-3 reports & Narrative for certification

Treatment Dates from Initial to Present

NAME & ADDRESS OF PERSON OR ENTITY TO WHOM INFO. WILL BE SENT

World Trade Center Health Program /

NIOSH for Certification

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.**

- [X] Alcohol and/or Substance Abuse Program Information
- [X] Mental Health Information
- [X] Genetic Testing Information
- [ ] HIV/AIDS-related Information

REASON FOR RELEASE OF INFORMATION

- [ ] Legal Matter
- [ ] Individual's Request
- [X] Other (please specify): Certification process

WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)

- [ ] Event:_____
- [ ] On this date:_____

I, or my authorized representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.

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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.

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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.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING FORM
X	
DATE	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT

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.

HHC USE ONLY

Date Received:	Initials of HIM employee processing request:
Date Completed:	Comments: