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 | WTC ENVIRONMENTAL HEALTH CENTER

Monitoring and Treatment 9.11 WTC Health Program

Authorization for Disclosure of Health Information for NYC Health + Hospitals Care Management

I. Information about the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information, as described below, to NYC Health + Hospitals' affiliated entities, subsidiaries, or other third-parties for the purpose of care coordination for WTC-certified conditions. This may include third-parties not affiliated with NYC Health + Hospitals. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information. By signing below, I acknowledge that I have read and understand this form.

Patient Name: **Date of Birth:**

911S Unique ID for Subscriber:

Description of the information that may be used or disclosed:
*Complete Health Records / Discharge Summary
*History & Physical Examination / Progress Notes
*Consultation Reports / Laboratory Tests/Pathology Reports
*X-ray Reports / Photographs, videotapes, digital or other images
*Other, Please specify: Treatment plans

I understand that this release can include information relating to:
*Acquired immunodeficiency syndrome (AIDS)
*Human immunodeficiency virus (HIV) infection
*Behavioral health service/psychiatric care
*Treatment for alcohol and/or drug abuse
*Genetic testing information

II. Important Information about Your Rights

***I have read and understood the following statements about my rights:**
***I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.**
***I may see and copy the information described on this form if I ask for it.**
***The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.** I understand, however, 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.

This authorization shall remain in effect until revoked in writing by patient or patient's personal representative, or the expiration event has occurred.

This authorization will expire on _____ (Date/Event)

***III.* Signature of Patient or Patient's Representative**

Patient Printed Name:_____Date: _____

Patient Signature: _____

Legal Guardian Printed Name & Relationship: _____

Legal Guardian Signature & Date: _____

HHC HIPAA for NIOSH/WTC-3

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

NYC H+H/Gouverneur WTC Clinic
227 Madison St, NY, NY 10002
Tel: 212-238-7400

SPECIFIC INFORMATION TO BE RELEASED:

Information Requested: Medical Records, tests, labs, PFT's, X-rays, progress notes, WTC-3 Report, & 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.**

- ☑ Alcohol and/or Substance Abuse Program Information
- ☑ Mental Health Information
- ☑ Genetic Testing Information
- ☐ HIV/AIDS-related Information

REASON FOR RELEASE OF INFORMATION

- ☐ Legal Matter
- ☐ Individual's Request
- ☑ Other (please specify): Certification Purpose

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.

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

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 HEALTHIX, FORMERLY 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 Healthix. I can obtain an updated list at any time by checking Healthix's website at www.Healthix.org or by calling 877-695-4749.

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.***

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
_____	_____
Date ____/_____/20____	Description of Personal Representative's Authority to Act on Behalf of Patient _____

Internal Use Only

Originating System Facility: _____ **Additional Restrictions:** _____

NYC HEALTH + HOSPITALS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: _____

DOB: ____/_____/_____

Medical Record Number: _____

By signing and dating the form below, I acknowledge that I have received a copy of the NYC Health + Hospitals' Notice of Privacy Practices.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DATE / TIME

If executed by a patient's personal representative, please print your name and indicate your relationship/authority to act on behalf of the patient:

_____

PERSONAL REPRESENTATIVE'S NAME

_____

RELATIONSHIP / AUTHORITY TO ACT ON BEHALF OF PATIENT

To be complete by NYC Health + Hospitals staff only if the patient refuses or is unable to sign:

☐ **Patient refused to sign**

☐ **Patient unable to sign**

_____

EMPLOYEE'S NAME

_____ _____

EMPLOYEE'S SIGNATURE DATE / TIME

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:

NYC HEALTH+ HOSPITALS

(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.

_____

Signature of Patient or Parent/Legal Guardian of Minor Patient

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)

_____

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.

Signature and Title of Witness

INTERPRETER: (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

NYC HEALTH + HOSPITALS

PATIENT MRN: _____

PATIENT CONSENT TO USE ELECTRONIC COMMUNICATIONS

Email and text messaging can be fast and convenient ways to communicate with your NYC Health + Hospitals health care providers. This form and Appendix provide information you need to decide whether you wish to use electronic means to communicate with your health care providers, and the authorization to do so.

I UNDERSTAND AND AGREE THAT:

1. Messages NYC Health + Hospitals sends to me by electronic communication may contain my protected health information and may be related to appointment reminders, preparation instructions for upcoming visits, billing matters, and other matters related to my health care.
2. I might be charged for text messages by my wireless carrier, and such text messages might be generated by an automated messaging system.
3. The information in any email or text messages that I send to or receive from NYC Health + Hospitals has the same level of security as other emails or text messages I send and receive, and might not be encrypted and might not be secure.
4. I should not use email or text messaging for emergency or other time-sensitive communications with my health care team, and email and text messaging should not be my only method of communication with my health care team.
5. I have read and fully understand the risks and conditions of use of electronic communications described in the Appendix to this consent form.

By signing below, I acknowledge that I have read and fully understand this consent form, including the information in the Appendix to this form. I understand the risks associated with electronic communications, including email and text messages, between my health care providers and me, and all of my questions have been answered. I understand that I may revoke this consent at any time and that such revocation must be in writing.

I agree to have my health care providers at NYC Health + Hospitals communicate with me using the following modes of electronic communication [check all that apply]:

☐ Email (specify address): _____ ☐ Text Messaging (specify cellular number): _____

_____

Patient Signature Phone Number(s)

_____

Printed Name of Patient Date Time am/pm

If the patient cannot consent for themself, the signature of the patient's legal guardian who is acting on behalf of the patient must be obtained.

_____

Signature of Legal Guardian Date Time am/pm

(Place a copy of the authorizing document in the medical record)

_____

Printed Name of Legal Guardian Date Time am/pm

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)
I have provided an accurate and complete interpretation of an explanation/discussion of this form between the staff and/or health care provider(s) and the patient or the patient's authorized representative.

_____ _____ **and** _____ **am**

Signature of Interpreter (if present), ID# and Agency Name **Date** **Time** **pm**

PATIENT MRN: _____

APPENDIX: Risks and Conditions Associated with Electronic Communications

Risks associated with using electronic communication devices:

NYC Health + Hospitals will use reasonable means to protect the security and confidentiality of information sent and received using electronic modes of communication, such as email and text messaging. However, because of the risks outlined below, NYC Health + Hospitals cannot completely guarantee the security and confidentiality of the information transmitted via electronic communication devices.

- Use of electronic communication devices to transmit information can increase the risk that such information might be disclosed to third parties.
- Others who have access to your cellular phone might have access to text, email, and voicemail messages sent to your cellular phone.
- Electronic communications containing your protected health information can be stored on mobile devices, and may be disclosed if the devices are lost or stolen.
- Electronic communications can introduce malware and viruses into your computer or mobile devices, and potentially damage them.
- Electronic communications can be forwarded, intercepted, distributed, stored, or even changed without your knowledge or permission.
- Even after copies of electronic communications are deleted, back-up copies may exist on a computer system of the cellular or email service provider.
- Electronic communications can more easily be misdirected, resulting in increased risk of being received by unintended and unauthorized recipients.
- Electronic communications can be easier to falsify than handwritten or signed hard copies. It is also not feasible to verify the true identity of the sender of the electronic communications, or to ensure that only the recipient can read the message once it has been sent.

Conditions for using electronic communication devices:

- NYC Health + Hospitals cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time.
- Therefore, if your electronic communication requires or invites a response from your health care provider and you have not received a response within a reasonable time period, it is your responsibility to follow up.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate. You are responsible for following up on your electronic communications and for scheduling appointments when necessary.
- Electronic communications should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Staff within NYC Health + Hospitals authorized to access your medical record, may have access to those communications.
- Your health care provider may forward electronic communications to authorized staff and those involved in the delivery and administration of your care. NYC Health + Hospitals will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.
- NYC Health + Hospitals is not responsible for information lost due to technical failures associated with your personal devices, or email or internet service provider.
- You are responsible for informing NYC Health + Hospitals of any changes in your email address, cellular phone number, or other account information necessary to communicate via electronic communication devices.