NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

Dear WTC Environmental Health Center Member,

Thank you for scheduling your medical appointment at our WTC clinic. To prepare for your visit, please review the following information carefully along with the enclosed forms.

This initial visit consists of two parts that occur within two separate appointments: The first appointment will be done remotely via telephone and the second will be either by phone or in-person at the WTC clinic. You will receive an automated reminder call before each appointment

1. **Appointment # 1 - Remote Visit by Phone**
   At the time of your first appointment you will receive 2-3 phone calls over 2-3 hours. ***Do not come to the WTC clinic***.

   - Nurse interview
   - Mental health screening
   - Psychosocial/Benefits counseling

2. **Appointment # 2 - Medical Visit (In-person or Remote by Phone)**
   Your second appointment will be scheduled in-person or remotely. As of December 23, 2021, most medical appointments are remote due to COVID conditions. ***Do not come to the WTC clinic unless you have been notified that this appointment will be in-person***. If you are not sure of your appointment type, you may contact the clinic or our Call Center at 1-877-982-0107 to confirm.

   - Exam by medical provider, may include:
     - Lab work
     - Pulmonary function testing
     - Chest X-ray

3. **Clinical Consent Forms**
   It is important that we receive your signed clinical consent forms. While they will not impact your care, these forms are important for our clinic records. We are also including forms to exchange medical information with other providers for the purposes of continuity of care. **Please sign and return these forms to us <u>within one week</u> of receiving this letter.** To make the process easier, please also include a photocopy of your government-issued ID.

   The forms that we need from you are as follows:

	Name of Clinical Consents	Check ✓before mailing/faxing back
1	General Consent for Treatment	☐
2	Authorization to Use, Receive and Disclose Health Information for Treatment, Payment and Health Care Operations	☐
3	NYCHHC Notice of Privacy Practices and Acknowledgement Form (**<u>only Acknowledgement Form</u>**)	☐
4	Acknowledgement of Patient's Bill of Rights and Responsibilities (**<u>only the signature page</u>**)	☐
5	NYCHHC HIPAA Authorization to Disclose Health Information—Continuity of Care	☐
6	NYS Authorization for Release of Health Information Pursuant to HIPAA	☐
7	Patient Consent for Electronic Communications	☐
8	Photocopy of your government-issued ID	☐

You may fax your forms back to us at:

NYC Health + Hospitals/Elmhurst – fax (347) 671-8467

If you are unable to fax your registration packet, please mail it back to us at:

Elmhurst Hospital
79-01 Broadway Rm D1-24
Elmhurst, NY 11373
Attn: WTC EHC

4. Research Consent Form

This Research Registry consent form, also called "Informed Consent Form to Participate and Authorization for Research", will allow us to use your data to understand the health effects of 9/11. The data that we use for research will not include personal health identifiers. Please review this form but **do not sign or return it.** During your visit, we will give you the opportunity to ask questions and to sign it at that time.

5. Cancer Screenings

These cancer screening forms are for your review only. **Do not sign or return these forms**, as we will ask you these questions during your visit.

6. General Information About Our Program

We would like you to explore the enclosed WTC Members Handbook. It includes information on member benefits, important contact information, details on certified conditions, health information privacy policies, and member responsibilities.

And finally, enclosed is the Coordination of Benefits fact sheet which explains the payer process of our program.

Sincerely,
Your Care Team at the WTC Environmental Health Center

Facility: **Elmhurst Hospital Center**

GENERAL CONSENT FOR TREATMENT

Form #1

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

Chart No.

Name

Unit

(Patient Imprint Card)

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**

Form #2

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:** _____

Form #3

Effective Date: January 1, 2021

NYC Health + Hospitals
Notice of Privacy Practices

This Notice of Privacy Practices ("NPP") describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction and Information

The New York City Health and Hospitals Corporation d/b/a NYC Health + Hospitals (also referred to as the "System") is required under Federal law, specifically the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your protected health information which includes providing you with a notice of its legal duties and a description of the types of information that we gather about you, with whom that information may be shared, and your rights. This NPP describes your privacy protections and other rights related to your health 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 NPP.

The term "health information," as used in this NPP, refers to any individually identifiable information which is created, received, maintained or transmitted by the System, and which concerns your health care and treatment, and payment for such care and treatment. Special privacy protections, not outlined within this NPP, may apply to HIV-related health information, substance use disorder information, mental health information, and genetic or genetic testing information.

This NPP describes the privacy practices that must be followed at all NYC Health + Hospitals' facilities, units, and entities, including all acute care hospitals and associated clinics; all Gotham Health diagnostic and treatment centers and associated extension clinics; all long-term acute care facilities and skilled nursing facilities; and all home and community based services and programs.

NYC Health + Hospitals reserves the right to revise this NPP. NYC Health + Hospitals reserves the right to make the revised or changed NPP effective for health information already maintained as well as any health information in the future. NYC Health + Hospitals will post a copy of the current NPP (with an effective date) in conspicuous locations at its facilities, units, and entities, and on its public website.

Uses and Discloses of Health Information for Treatment, Payment and Health Care Operations

Treatment. The System may use and disclose your health information to provide you with medical treatment, care or services, and may disclosre your health information to health care providers or other workforce members who are involved in your care. Different departments of a hospital may also share your health information to coordinate the different health care services you may need, such as prescriptions, lab work, and x-rays. When necessary, the System may also disclose your health information to persons outside the System who may be involved in your care. *For example:*

A health care provider treating you for a broken leg may need to know from another health care provider if you have diabetes because diabetes may slow the healing process and they need to arrange for appropriate services.

Payment. The System may use and disclose your health information to obtain payment for your health care services and treatment. The System may use and disclose health information to your health plan about a treatment or procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover it. For health care or services paid for in full by you, you may request that the System limit the health information shared with your insurance company, to the extent permitted by law. *For example: The System may need to give your health plan information about surgical procedures you received at NYC Health + Hospitals so your health plan will pay the System or reimburse you for such procedures.*

Health Care Operations. The System may use and disclose your health information to perform operations on a daily basis and to make sure that NYC Health + Hospitals' patients receive quality care. The System may also combine health information about many patients to run statistics or analyses to determine the effectiveness and necessity of services provided. When needed, the System may also disclose health information to contracted accountants, consultants, and other professionals who support the operations of the various programs, entities and facilities. *For example: The System may use your health information to review the quality of the treatment and services it provides.*

Appointment Reminders. The System may use and disclose your health information to contact you with reminders that you have an appointment at a facility, unit or entity.

Uses and Discloses of Health Information Where Authorization is Required

NYC Health + Hospitals must obtain your written authorization before it can use or disclose your health information in the following situations:

Marketing. The System must obtain your written authorization before it can use your health information to communicate with you about purchasing or using a product or service, unless the communication is made face-to face between you and the System, or consists of a promotional gift of nominal value provided to you by the System. The following situations, however, do not require prior written authorization, unless the System receives payment from a third party in exchange for communicating with you: (i) health-related benefits and services; (ii) drug Information; and (iii) treatment alternatives.

Sale of Health Information. NYC Health + Hospitals will not sell your health information without written authorization.

Uses and Discloses of Health Information Where Authorization is Not Required

NYC Health + Hospitals does not need to obtain your written authorization before disclosing your health information in the following situations:

Facility Directory. The System may use certain health information about you in the facility directory at the hospital while you are hospitalized. This health information may include your name, location

in the facility, your general condition and your religious affiliation. *Note:* Only members of the clergy or clergy workforce members will be told your religious affiliation. If you would prefer that the System not include this health information in the facility directory, you have the right to object to including such information, and may do so by contacting the facility's Admitting or Health Information Management Department.

Fundraising Activities. The System may use or disclose your health information to contact you for fundraising purposes for the System's facilities and health care operations. NYC Health + Hospitals may also share your health information with a System-related foundation or Business Associate for the same purposes. To opt-out of receiving this type of communication, you can email a written request to optoutforfundraising@nychhc.org. You cannot be denied treatment, or any other benefit or service for choosing not to receive fundraising communications.

Research. If you participate in a clinical trial, NYC Health + Hospitals will ask for your written permission before using or sharing your health information. In certain circumstances, the System may use your health information without your written permission for a research study after conducting 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.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, the System may disclose your health information to a family member or friend who is involved in your care or the payment for your care.

Individuals Who May Act on Your Behalf. The System may disclose your health information to a personal representative, including a parent or guardian.

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

Military and Veterans. If you are a member of the armed forces, the System may disclose your health information as required by military command authorities.

Workers' Compensation. The System may disclose your health information to the Workers' Compensation Board or to similar programs as necessary.

Public Health Activities. The System may use and disclose your health information for public health purposes, such as to prevent the spread of disease, or to receive reports of certain medical conditions, births, deaths, abuse, neglect, and domestic violence.

Health Oversight Activities. The System may use and disclose your health information to a health oversight agency for activities authorized by law, which include audits, investigations, and inspections.

Legal Proceedings. If you are involved in a lawsuit or a legal dispute, the System may disclose your health information in response to a court or administrative order. The System may also disclose your health information 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. The System may use and disclose your health information for law enforcement purposes, including the following: (i) to identify or locate a suspect, fugitive, material witness, or missing person; (ii) in circumstances pertaining to victims of a crime; (iii) in the case of deaths we believe may be the result of criminal conduct; (iv) in the case of crimes occurring at a NYC Health + Hospitals facility; and (v) 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. The System may use and disclose your health information in order to notify, or assist in locating, individuals if they have legal authority to act on your behalf, a 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 had expressed in writing.

Coroners, Medical Examiners, Funeral Directors, and Organ Donations. The System may use and disclose your health information to a coroner, medical examiner, or funeral director, as necessary to carry out their duties. The System may also use and disclose your health information for the purposes of organ, eye, and tissue donations.

Disaster Relief. The System may use and disclose your health information to a public or private entity authorized by law or other authority to assist in disaster relief efforts, for the purpose of coordinating notifications to your family members, next of kin, personal representative, or others responsible for your care.

National Security and Intelligence Activities. The System may disclose your health information to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. The System may disclose your health information to authorized Federal officials so they may provide protection to the President, other authorized persons, foreign heads of state, or to conduct special investigations.

Rights Regarding Your Health information

You have the following rights regarding health information that the System maintains about you:

Right to Access and Copy. You have the right to request access to and obtain a copy of your health information, except for psychotherapy notes and information pertaining to an ongoing clinical research trial. You have the right to request copies of your medical records in the format of your choice. To access or request a copy of your health information please submit your request in writing to the facility or entity's Health Information Management Department. The System reserves the right, under limited circumstances, to deny access to your health information, and if so, to provide you with a written explanation for the denial, as well as your right to appeal that decision. The System may impose a reasonable fee to cover the costs of creating copies of medical records. The System is required to notify you in writing of any anticipated fees prior to sending the requested information, if the requested health information will be delayed for any reason, or if the requested health information cannot be provided in the format requested.

Right to Amend. If you feel that your health information that the System maintains is incorrect or incomplete, you have the right to request that the System amend your health information for as long as the information is kept by or for the System. To request an amendment to your health information, please submit your request in writing to the facility or entity's Health Information Management Department. You must provide a reason to support your request for an amendment. Under limited circumstances the System may deny your request. If your request is denied, the System must provide you with a written explanation as to why it was denied.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures," which lists how the System has disclosed your health information. The list will not include certain disclosures, such as information shared for your treatment, payment, or health care operations, or disclosures made with your authorization. To request an accounting of disclosures please submit your request in writing to the facility or entity's Health Information Management Department. Your request must include a time period of disclosures that may not be longer than six years, and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free of charge. For additional lists, the System may charge a reasonable fee.

Right to Request Restrictions. You have the right to request a restriction on your health information that System uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on the health information that the System discloses about you to someone who is involved in your care, such as a family member or friend. To request restrictions on your health information, please submit your request in writing to the facility or entity's Health Information Management, Admitting or Registration Department. *The System is not required to agree to your restriction request.* If agreed, however, the System will comply with your request unless the health information is needed to provide you with emergency treatment.

Right to Request Alternative Communications. You have the right to request that the System communicate with you about medical matters or your health information in an alternative manner or location. To request alternative communication methods, please submit your request in writing to the facility or entity's Health Information Management Department. Your request must specify how you wish to be contacted. The System will not ask you for the reason for your request, and will accommodate all reasonable requests.

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 the System determines that your health information has been potentially compromised (referred to as a "breach"). If a breach of your health information occurs, you will be notified of the breach in writing, within 60 days of when the breach was discovered.

Right to a Paper Copy of this NPP. You have the right to a copy of this NPP at any time. You may also obtain a copy of this NPP by visiting NYC Health + Hospitals' website at https://www.nychealthandhospitals.org/ or by contacting the facility or entity's Health Information Management, Admitting or Registration Department.

Right to Revoke Authorization. If you provide the System with authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the System will no longer use or disclose your health information for the reasons covered by your written authorization. The System is unable to retract any disclosures already made with your authorization.

Complaints. If you believe your privacy rights have been violated, that your health information has been improperly accessed, used or disclosed or have concerns about the System's privacy practices, please contact the Office of Corporate Compliance, Corporate Privacy and Security Officer by email at CPO@nychhc.org, or anonymously and confidentially, via the System's toll-free Compliance Helpline at 1-866-HELP-HHC. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. *You will not be penalized for filing a complaint.*

Form #3 (return only this page)

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 completed 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

Form #4

NYC HEALTH+ HOSPITALS

Patients' Rights and Responsibilities

These Patients' Rights and Responsibilities are designed to establish an equal and effective partnership between doctors, health care providers and patients, which will enable each NYC Health + Hospitals facility to promote and protect the best health care possible for its patients in the fullest sense, to achieve total physical, mental and social well-being for each patient.

Patient Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
6. Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet: "Deciding About Health Care— A Guide for Patients and Families."
11. Refuse treatment and be told what effect this may have on your health.
12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. Privacy while in the hospital and confidentiality of all information and records regarding your care.
14. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

15. Review your medical record without charge, and obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. Receive an itemized bill and explanation of all charges.
17. View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.
18. Challenge an unexpected bill through the Independent Dispute Resolution process.
19. Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
20. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
21. Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law (PHL) § 2803(1)(g); Patient's Rights, 10 NYCRR, §§ 405.7, 405.7(a)(1), 405.7(c).

Patient Responsibilities

As a patient at a NYC Health + Hospitals hospital, your responsibilities are:

1. To provide, to the best of your knowledge, accurate and complete information to your health care provider about your present and past medical conditions and all other matters pertaining to your health.
2. To report unexpected changes in your condition to your health care providers.
3. To inform your health care providers whether or not you understand the plan of care and what is expected of you.
4. To follow the treatment plan recommended by your health care providers.
5. To keep appointments, and if you cannot, notify the proper person.
6. To be responsible for the results of your own actions if you refuse treatment or do not follow the providers' instructions.
7. To be considerate of the rights of other patients and hospital personnel, and to follow hospital policy and regulations regarding care and conduct.
8. To fulfill your financial obligations to the hospital as promptly as possible.
9. Respect the property of other persons and of the hospital.

Form #4 (return only this page)

NYC HEALTH + HOSPITALS **PATIENTS' BILL OF RIGHTS AND RESPONSIBILITIES** **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' Patients' Bill of Rights and Responsibilities.

_____

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 completed 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

Form #5

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

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373
Medical Records

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): Continuity of care/ coordination of services

WHEN WILL THIS AUTHORIZATION EXPIRE? (Please check one)

- ☒ Event: Upon discharge 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:

Form #6

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

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

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

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NYC HEALTH + HOSPITALS

Form #7

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.

Form #8

Please include a photocopy of a government-issued form of identification for our records.

This page has been intentionally left blank.

The following forms are for you to review only.
They do not need to be printed, signed, or returned.

NYU Langone Health

INFORMED CONSENT FORM TO PARTICIPATE AND AUTHORIZATION FOR RESEARCH

Title of Study: **NYU/Bellevue WTC Health Impacts Research Registry**

Principal Investigator:
Joan Reibman, MD
Department of Medicine
New York University School of Medicine
550 1st Avenue
New York, NY 10016
Tel: 212-263-6479

1. What is the purpose of this 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 IRB 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.

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2. How long will I be in the study? How many other people will be in the study?

We estimate that the following number of subjects will enroll in this study across all sites: 20,000

SUBJECT PARTICIPATION:
☐ Inpatient
☒ Outpatient
☒ other [healthy subjects, etc.] Please specify: Healthy 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.

3. What will I be asked to do in the study?

We are asking for your permission to put your medical record information in the NYU/Bellevue WTC Health Impacts Research Registry. Identifiers will be removed from the identifiable private information. After such removal the information may be used for future research studies or shared with other researchers and we will not request additional informed consent from you to use these specimens as we have noted here.

4. What are the possible risks or discomforts?

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.

5. What are the possible benefits of the study?

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.

6. Will I be paid for being in this study?

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.

7. How will you protect my 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.

8. HIPAA Authorization.

As noted in the Confidentiality section above, federal law requires us, and our affiliated researchers, health care providers, and physician network to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health conditions. We are asking for your permission (authorization) to use and share your health information with others in connection with this study- in other words, for purposes of this research, including conducting and overseeing the study.

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Your treatment outside of this study, payment for your health care, and your health care benefits will not be affected even if you do not authorize the use and disclosure of your information for this study.

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.

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.

What if I do not want to give permission to use and share my information for this study?
Signing this form is voluntary. You do not have to give us permission to use and share your information, but if you do not, you will not be able to participate in this study. Refusing to sign will not affect your health care, participation in the WTC Environmental Health Clinic, or payment for your health care.

Can I change my mind and withdraw permission to use or share my information?
Yes, you may withdraw or take back your permission to use and share your health information at any time for this research study. If you withdraw your permission, we will not be able to take back information

that has already been used or shared with others. To withdraw your permission, send a written notice to the principal investigator for the study noted at the top of page 1 of this form.

How long may my information be used or shared?
Your permission to use or share your personal health information for this study will never expire unless you withdraw it.

9. The Institutional Review Board (IRB) and how it protects you

The IRB reviews all human research studies – including this study. The IRB follows Federal Government rules and guidelines designed to protect the rights and welfare of the people taking part in the research studies. The IRB also reviews research to make sure the risks for all studies are as small as possible. The NYU IRB Office number is (212) 263-4110. The NYU School of Medicine's IRB is made up of:

- Doctors, nurses, non-scientists, and people from the Community

10. Who can I call with questions, or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on top of the page 1 of this consent form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Institutional Review Board (IRB) at (212) 263-4110.

11. Permission to contact you about future research

This section authorizes the principal investigator and his or her co-investigators to contact you 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 you agree, then someone from Dr. Reibman's research staff might contact you in the future and he or she will tell you about a research study. At that time, you can decide whether or not you are interested in participating in a particular study. You 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.

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 at any of the WTC EHC clinics. 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 must join in any study.

12. Signature to participate in the Research Registry

When you sign this form, you are agreeing to take part in this research registry as described to you. This means that you have read the consent form, your questions have been answered, and you have decided to volunteer.

Name of Subject (Print)	Signature of Subject	Date

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

For subjects unable to give consent, the consent for study participation and authorization to collect and use protected health information is given by the following authorized subject representative:

Name of Authorized Subject Representative (Print)	Signature of Authorized Subject Representative	Date

Select the category that best describes the above Authorized Subject Representative:

- ☐ Court-appointed guardian
- ☐ Health care proxy
- ☐ Durable power of attorney
- ☐ Family member/next of kin; for this category describe relationship below:

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Witness to Consent of a Subject Who Cannot Read or Write

Statement of Witness

I represent that the consent form was presented orally to the subject in the subject's own language, that the subject was given the opportunity to ask questions, and that the subject has indicated his/her consent and authorization for participation by (check box that applies).

- ☐ Subject making his/her own "X" above in the subject signature line
- ☐ Subject showed approval for participation in another way; describe:

Name of Witness (Print)	Signature of Witness	Date

DC 08/29/2019

NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

LUNG CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY ALL PATIENTS

The US Preventive Services Task Force (USPSTF) recommends annual screening for lung cancer for adults at risk. The WTCHP provides lung cancer screening for WTC-certified members who meet the USPSTF criteria. Information about lung cancer screening is in your folder. The screening consists of a low-dose computed tomography of the chest (CT scan). This questionnaire is part of the screening process to determine if you are eligible. If eligible, we will arrange the CT scan at Bellevue Hospital.

Please complete these questions. Thank you.

1. Are you between 55 and 80 years old?	☐ Yes ☐ No **If NO, please stop here**
2. Do you currently smoke or have you quit smoking within the last fifteen (15) years?	☐ Yes ☐ No **If NO, please stop here**
3. If you quit smoking, when did you quit?	Month_____ Year _____ ☐I Can't Remember
4. During the time you smoked, **on average**, how many packs of cigarettes did you smoke each day?	_____ packs per day *20 cigarettes = 1 pack*
5. For how many years did you smoke cigarettes regularly?	_____ years
6. Have you ever been diagnosed with lung cancer?	☐ Yes ☐ No
7. If you are currently smoking, are you interested in smoking cessation?	☐ Yes ☐ No

TO BE COMPLETED BY PROVIDER (Name of Provider _____)

INCLUSION CRITERIA

8. Does the patient fit ALL the inclusion criteria for routine lung cancer screening	☐ Yes ☐ No ☐ I Don't Know **YES, If patient** ✓ **is age 55 – 80** ✓ **smoker within past 15 years** ✓ **≥ 30 p-y hx** *(# of packs per day X # of years smoked = packs-yr)*

EXCLUSION CRITERIA

9. Does the patient need other lung or lung cancer diagnostic evaluation? Ex. Symptoms of cough, blood, weight loss, pneumonia	☐ Yes ☐ No
10. Does the patient have extenuating circumstances that preclude lung cancer screening?	☐ Yes ☐ No ☐ I Don't Know
11. Has the patient had a CT scan within the past 12 months?	☐ Yes ☐ No ☐ I Don't Know

ASSESSMENT

12. Does the patient fit all inclusion criteria and no exclusion criteria?	☐ Yes ☐ No **YES, if patient answers "Yes" to <u>any</u> of questions #8 – #11** **If NO, please stop here**
13. Is the patient interested in lung cancer screening through the WTC EHC?	☐ Yes ☐ No ☐ I Don't Know
14. Has the WTC provider ordered a Lung Cancer Screening CT at Bellevue Hospital	☐ Yes ☐ No

<u>Instructions to Schedule Lung Cancer Screening at Bellevue Hospital</u>

Under MEDICATIONS / ORDER, order a CT Chest Low Dose Initial Screening. You will be asked to complete questions under the order. These have been included in the WTC Lung Cancer Screening Questionnaire.

<u>Instructions If Patient Wants Smoking Cessation</u>

1. Write prescription for smoking cessation aids.
2. Provide 2 weeks of gum and / or Nicorette patch, depending on patient's preference.
3. Put smoking cessation order in EMR (Bellevue and Gouverneur only).
4. Patient will receive follow up from smoking cessation counselor, Jesus 917- 239- 3850 (Bellevue) and Lisette Mojica (Gouverneur).
5. Refer patients at Elmhurst to the Smoking Cessation Program (718-334-2550) or the counselor, Bienvenido Medrano (718) 334-1517.
6. Alternatively, patient contacts New York State 1-866-NY-QUITS (1-866-697-8487) or https://www.health.ny.gov/publications/3485/

NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

MAMMOGRAPHY SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides routine breast cancer screening for WTC-certified members who meet the US Preventive Services Task Force (USPSTF) criteria. Information about breast cancer screening is provided in your folder. The USPSTF recommends a mammogram every two years for women between the ages of 50 – 74. If there is a history of breast cancer in the family, screening is recommended to start at age 40. These recommendations apply to women who do not have a known risk.

Please complete these questions. Thank you.

1. Are you female?	☐ Yes ☐ No **If NO, please stop here.**
2. What is your age?	☐ Less than 40 ☐ 40 – 49 ☐ 50 – 75 ☐ Greater than 75 **If you are less than 40 years old or greater than 75 years old, please stop here.**
3. Have you had a mammogram in the previous two (2) years?	☐ Yes ☐ No ☐ I Don't Know **If you had a mammogram in the past two (2) years, please indicate the month and year.** Month _____ Year _____
4. Has your mother, sister or child been diagnosed with breast cancer?	☐ Yes ☐ No ☐ I Don't Know
5. Do you have a history of any of the following? • pre-existing breast cancer • a previously diagnosed high risk breast lesion • a known genetic risk (BRCA1 or BRCA2) • familial breast cancer syndrome	☐ Yes ☐ No ☐ I Don't Know
6. If you fit criteria for breast cancer screening, where would you prefer to have it done?	☐ My own provider ☐ Bellevue ☐ Gouverneur ☐ Elmhurst

TO BE COMPLETED BY NURSE (Name of RN _____)

7. Does patient fit criteria for routine breast cancer screening?	☐ Yes ☐ No **YES, if patient is female and between ages 50 – 75 or patient is between ages 40-49 and answered YES to question #4**
8. Does patient want a mammogram at Bellevue, Gouverneur or Elmhurst?	☐ Yes ☐ No **If patient answers YES to question #6 and fits criteria, alert Provider to order in EMR at Bellevue, Gouverneur or Elmhurst**
9. Is patient at risk for breast cancer?	☐ Yes ☐ No **If YES to question #5, refer patient to provider for diagnostic referral**

Version Updated. 7/12/16, 7/23/18, 5/9/19, 10/25/19

NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

COLORECTAL CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides colorectal cancer screening for WTC-certified members who meet the U.S. Preventive Service Task Force criteria (USPSTF). Information about colorectal cancer screening is provided in your folder. Common ways to screen include a colonoscopy or yearly stool testing. Colonoscopy can be scheduled at Bellevue or Elmhurst Hospital. Stool testing can be performed at any of WTC EHC sites.

Please complete these questions. Thank you.

1. Are you currently between 50 – 75 years old?	☐ Yes ☐ No **If NO, please stop here**
2. Have you had a colonoscopy within the last 10 years?	☐ Yes Month _____ Year _____ ☐ No ☐ I Don't Know
3. Do you have a diagnosis of polyps in your colon?	☐ Yes ☐ No ☐ I Don't Know
4. Do you have Inflammatory Bowel Disease?	☐ Yes ☐ No ☐ I Don't Know
5. Do any of your parents, siblings or children have colorectal cancer?	☐ Yes ☐ No ☐ I Don't Know
6. Do you have colorectal cancer?	☐ Yes ☐ No ☐ I Don't Know
7. If you fit criteria which screening test would you prefer to have?	☐ Colonoscopy ☐ Stool (FIT) test ☐ None / Refused

TO BE COMPLETED BY NURSE OR OTHER (Name _____)

8. Does patient meet inclusion criteria for routine colorectal screening?	☐ Yes ☐ No **YES, if patient, (MUST FIT ALL CRITERIA)** ✓ **is between 50 – 75 years old** ✓ **has not had a colonoscopy within last 10 years**
9. Does patient meet criteria for more frequent screening or diagnostic evaluation (symptoms, family history, polyps, IBD, cancer)	☐ Yes ☐ No **If YES to <u>any</u> of questions #3 - 6, discuss with provider**
10. Is there an extenuating circumstance?	☐ Yes ☐ No **If YES, do <u>not</u> schedule routine screening**

Version Updated. 1/15/16, 2/16/16, 7/12/18, 5/9/19, 8/28/19, 10/25/19

ROUTINE COLORECTAL SCREENING

If the answers to question # 8 is YES and questions #9 and #10 are NO, patient meets inclusion criteria for routine screening. Schedule a routine colorectal screening.

11. If patient meets criteria, which colorectal screening approach does the patient prefer?	☐ Colonoscopy ☐ FIT ☐ None / Refused ✓ **Provider to note in EMR if patient refuses screening**
12. If patient would like to have colonoscopy screening, where would they prefer to have it done?	☐ Bellevue ☐ Elmhurst ☐ Outside Provider ✓ **Provider to note in EMR if patient wants screening with external provider.** ✓ **If screening is preferred at Bellevue, Nurse to ask Provider to request appointment for colonoscopy evaluation with WTC GI in EMR**
13. If patient would like to have FIT testing, where would they prefer to have it done?	☐ Bellevue ☐ Elmhurst ☐ Gouverneur ✓ **Nurse to ask Provider to order FIT in EMR** ✓ **Nurse provides FIT materials with instructions** ✓ **Front desk schedules patient for 1 year monitoring with FIT testing.** ✓ **Provider gets results in queue**

Version Updated. 1/15/16, 2/16/16, 7/12/18, 5/9/19, 8/28/19, 10/25/19

NYC HEALTH+ HOSPITALS | WTC ENVIRONMENTAL HEALTH CENTER

WTCHP ID # _____

Last Name _____

First Name _____

DOB _____

CERVICAL CANCER SCREENING QUESTIONNAIRE

DATE: MONTH _____ DAY _____ YEAR _____

TO BE COMPLETED BY PATIENT

The WTC Health Program provides cervical cancer screening for WTC-certified members who meet the U.S. Preventive Service Task Force criteria (USPSTF). A PAP smear is recommended every 3 years for women between the ages of 21-65 or a combined PAP and screening for the human papilloma virus (HPV) is recommended every 5 years for women between the ages of 30-65.

Please complete these questions. Thank you.

1. Are you biologically female?	☐ Yes ☐ No **If NO, please stop here**
2. Are you between 21 and 65 years old?	☐ Yes ☐ No **If NO, please stop here**
3. Do you still have your cervix?	☐ Yes ☐ No ☐ I Don't Know **If NO, please stop here**
4. When was your last pap smear?	Month _____ Year _____ ☐ I Don't Know
5. Do you have cervical cancer or abnormal PAP smear?	☐ Yes ☐ No ☐ I Don't Know
6. If you fit criteria for cervical cancer screening, where would you prefer to have it done?	☐ My own provider ☐ Bellevue ☐ Gouverneur ☐ Elmhurst

TO BE COMPLETED BY NURSE **Name of RN _____**

7. Does patient fit criteria for routine cervical cancer screening?	☐ Yes ☐ No **YES, if patient (MUST FIT ALL CRITERIA)** ✓ **Is biologically female** ✓ **Between ages 21 – 65** ✓ **Has a cervix or doesn't know** ✓ **Has NOT had a PAP smear within the past three (3) years.** ✓ **Does not have cervical cancer or abnormal PAP screening**
8. Does patient need diagnostic cervical cancer screening?	☐ Yes ☐ No ☐ I Don't Know (Yes to #5, has history of cervical cancer or abnormal PAP smear)
9. Is the patient interested in cervical cancer screening through the WTC EHC?	☐ Yes ☐ No ☐ I Don't Know **If YES, Nurse to alert Provider to order consultation in EMR with GYN clinic at Bellevue, Gouverneur or Elmhurst**

Version Updated. 3/10/15, 7/20/18, 5/9/19, 10/25/19

All About Coordination of Benefits

For Survivors in the WTC Health Program

9.11 WTC Health Program

Medically necessary treatment and pharmacy services for certified WTC-related health conditions are provided at no cost to Survivors in the World Trade Center (WTC) Health Program through a process called "coordination of benefits." The Program is required by law to follow this process.

What is Coordination of Benefits?

"Coordination of benefits" is the process that helps determine who pays a medical bill first when there is more than one potential payer. A payer can be an insurance plan or health benefits program.

The James Zadroga 9/11 Health and Compensation Act of 2010 (Zadroga Act)—the law that created the WTC Health Program—sets the order in which these payers are responsible for paying for WTC-related services.

How does this apply to my WTC-related care?

As a Survivor, your primary health insurance first pays its share of the cost for all treatment and pharmacy services received through the Program for a certified WTC-related health condition. Your primary insurance may be a type of private insurance, group health, or public health insurance such as Medicare or Medicaid.

The Program bills private insurance first, then public insurance. Once your health insurance providers have paid, the WTC Health Program pays any remaining amount. This leaves no out-of-pocket cost to you.

You are not responsible for paying any co-insurance charges, copayments, or deductibles for care of your certified WTC-related health conditions if that care is from a Program provider.

Note: For initial health evaluations and annual monitoring exams, the Program pays in full. If your certified condition is work-related and you have a workers' compensation claim for the condition, the Program will pay initially and then seek recoupment from either the workers' compensation carrier or the settlement, where applicable.

What do I need to do?

You must provide your primary health insurance information when receiving services from the WTC Health Program. This means you need to give it to:

- Your Clinical Center of Excellence (CCE) or the Nationwide Provider Network (NPN).
- Any specialist or external provider you see for your certified WTC-related health condition. Tell the provider's staff your visit is for a WTC-related condition. This will help make sure that they bill your visit properly.
- A retail, community, or Program-affiliated mail order pharmacy when filling a WTC-related prescription. Also give them your WTC Health Program/Optum pharmacy card and tell them to bill the WTC Health Program last.

What if I don't have health insurance?

The WTC Health Program is not an insurance plan. The Zadroga Act requires that Program members have primary health insurance in order to coordinate benefits and to cover costs for conditions that are not certified by the Program.

If you do not have health insurance, you might be eligible for public or private health insurance, such as Medicaid, Medicare, health insurance offered through the Marketplace at **www.healthcare.gov**, or other options.

Your benefits counselor or case manager at your CCE or the NPN can help you find and apply for health insurance.

What if I have additional questions?

Visit **www.cdc.gov/wtc/cob.html** or call the WTC Health Program call center at 1-888-982-4748.

11/20

How Coordination of Benefits Works in the WTC Health Program

You Give Insurance Info

You provide your WTC Health Program clinic and pharmacy with your primary health insurance info (private and/or public)

You Receive Care

You receive WTC-related medical care from a Program clinic, Program-affiliated provider, or fill a WTC-related prescription

Insurance Pays Bill First

Your primary health insurance pays its share of the cost of the care or medication

Program Pays Next

The Program pays any remaining cost, including co-pays and deductibles

No Cost to You

At the end of this process, there is no out-of-pocket cost to you for WTC-related medical care through the WTC Health Program

Did you get a bill? If you receive a bill for WTC-related care, please call your CCE, the NPN, or the WTC Health Program call center so that the issue can be addressed.

Note: If your certified condition is work-related and you have a workers' compensation claim for the condition, the Program will pay initially and then seek recoupment from either the workers' compensation carrier or the settlement, where applicable.