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NYC HEALTH+ HOSPITALS

Internal Use Only

Patient Name: _____

DOB: ___ / ___ / ___

Medical Record Number: _____

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

AS DESCRIBED IN THIS FORM, I HEREBY AUTHORIZE THE NYC HEALTH + HOSPITALS (THE "SYSTEM" OR "SYSTEM-OPERATED FACILITIES") TO USE, RECEIVE, AND DISCLOSE MY HEALTH INFORMATION AS THE SYSTEM DEEMS NECESSARY FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND TO ACCESS MY HEALTH INFORMATION THROUGH NY CARE INFORMATION GATEWAY, A HEALTH INFORMATION EXCHANGE ("HIE"), IN WHICH THE SYSTEM PARTICIPATES.

WHAT IS CONSIDERED HEALTH INFORMATION?

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

WHAT ARE HEALTH CARE PROVIDERS?

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

WHAT ARE THE NAMES OF THE SYSTEM-OPERATED FACILITIES?

Bellevue Hospital Center; Coler Rehabilitation and Nursing Care Center; Henry J. Carter Specialty Hospital and Nursing Facility; Coney Island Hospital; Cumberland Diagnostic & Treatment Center ("D&TC"); Dr. Susan Smith McKinney Nursing and Rehabilitation Center; East New York D&TC; Elmhurst Hospital Center; Gouverneur Health Care Services; Harlem Hospital Center; Jacobi Medical Center; NYC Health + Hospital/At Home; Kings County Hospital Center; Lincoln Medical and Mental Health Center; Metropolitan Hospital Center; Morrisania D&TC; North Central Bronx Hospital; Queens Hospital Center; Sydenham D&TC; Sea View Hospital Rehabilitation Center & Home; Segundo Ruiz Belvis D&TC; and Woodhull Medical and Mental Health Center.

PURPOSE AND DESCRIPTION OF AUTHORIZATION FOR THE SYSTEM TO DISCLOSE INFORMATION

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

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

3) *FOR HEALTH CARE OPERATIONAL PURPOSES, UNLESS STATED OTHERWISE, I AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION* to contractors, agents, and other third parties that provide services or functions to or on behalf of a NYC Health + Hospitals facility such as, but not limited to, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial, claims processing or administration, data analysis, insurance, risk management, compliance, processing or administration, medical records management and operations, laboratory analyses, utilization review, quality assurance, billing,

benefit management, practice management, training, repricing services and activities, and health information exchanges (see information on health information exchanges directly below) that perform record management functions, to the extent that the System deems such disclosure necessary to carry out its health care operations.
Any disclosure of my health information pursuant to this authorization, however, will be limited to the amount of information that is necessary to carry out the purpose of the disclosure.

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

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

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

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

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

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

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

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

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

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

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE
By signing directly below, I, or my personal representative, authorize NYC Health + Hospitals and other HPs to use, receive, and disclose my health information as described in this form. I sign this authorization willingly and understand the nature of the authorization I am providing. I understand that nothing in this form restricts NYC Health + Hospitals from releasing my health information where it is otherwise authorized by state or Federal law to do so. I am aware that my consent does not obligate NYC Health + Hospitals to make any disclosures as described in this form. ***I understand that the choice I make on this form will NOT affect my ability to get medical care. I understand that I may restrict the disclosure of my health information for purposes of payment, or to HIEs and family members***, by indicating below (please check all that apply):

Patient Name: _____ MRN: _____

[ ] **I AUTHORIZE** the release of my health information for TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONAL PURPOSES.

[ ] **I DO NOT AUTHORIZE** the release of my health information for PAYMENT PURPOSES. I understand that by selecting this option, I will be responsible for all costs and payments for any health care treatment and services rendered to me.

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

[ ] **I DO NOT AUTHORIZE** the release of my health information to my FAMILY MEMBERS or OTHER INDIVIDUALS who are involved in my care without my additional written consent unless such individuals are authorized by law to make health care decisions on my behalf.

I UNDERSTAND THAT I MAY DISCUSS ANY OTHER DISCLOSURE RESTRICTION NOT LISTED ABOVE WITH MY NYC HEALTH + HOSPITALS TREATING PROVIDER OR PATIENT REPRESENTATIVE.

Signature of Patient or Personal Representative	If not Patient, Name of Personal Representative Signing Form
_____	_____
Date ____/_____/20____	Description of Personal Representative's Authority to Act on Behalf of Patient _____

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Originating System Facility: _____ Additional Restrictions: _____