NYSP NEW YORK SURGICAL PARTNERS

Tele: 516-627-5262
Fax: 516-627-0641

PATIENT INFORMATION SHEET

Have you ever been seen in the past by our Doctors? **YES** or **NO**

Who is your appointment with today?

☐ Gary Gecelter, MD ☐ Eugene Rubach, MD ☐ George DeNoto, MD ☐ Daniel Popowich, MD ☐ Michael Giuffrida, MD ☐ Jonathan Zagzag, MD ☐ Mitchell Chorost, MD

Patient Name: _____

Street: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____

Social Security: _____ Gender: Male / Female Marital Status: S M D W Spouse's name: _____

Employer: _____

Employer's Address: _____ City: _____ State/Zip: _____

Business Number: _____ Email Address: _____ @ _____

☐ I agree to be contacted via email about confidential health information

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Prefer Not to Answer
☐ Native Hawaiian or Other Pacific Islander
☐ White or Caucasian
☐ Other: _____

Who Referred you? _____ Phone: _____

Address: _____

In Case of Emergency Notify: _____ Phone: _____

Relationship: _____ Work Phone: _____

Primary Insurance Company: _____

Address: _____ City: _____ State/Zip: _____

Identification# _____ Group#: _____ Co-Pay: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's SS# _____ Policyholders DOB: _____

Insurance Plan Effective Date: _____ Does your insurance require a referral from your Primary Care? Y or N

Secondary Insurance Company: _____

Address: _____ City: _____ State/Zip: _____

Identification# _____ Group#: _____ Co-Pay: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's SS# _____ Policyholders DOB: _____

Insurance Plan Effective Date: _____ Does your insurance require a referral from your Primary Care? Y or N

***Note: Address, DOB & SS# of policyholder is required if other than yourself.**

Assignment of Benefits

I hereby authorize St. Francis Surgical Associates, PC to release all information required by my insurance to process my claims.
I hereby authorize assignment of benefits to be paid directly to St Francis Surgical Associates, PC
This arrangement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original
I understand that I could be financially responsible for all non-covered medical services.

Patient Signature: _____ Date: _____

A copy of your insurance card is required for our files and a Co-Payment may apply at the time of visit - Rev-1/9/19

NYSP NEW YORK SURGICAL PARTNERS

Hernia Institute | Cancer Center | Gastrointestinal Center

Affiliated with St. Francis Hospital, Roslyn, NY + Catholic Health Services of Long Island

NEW YORK SURGICAL PARTNERS

Today's Date: _____

Name: _____ Date of Birth: _____

LAST FIRST

Primary Care Physician: _____

What is the reason for your visit? _____

GENERAL

- ☐ Loss of Weight
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Sweats

SKIN

- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Hives/itching
- ☐ Rash

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swollen Ankles
- ☐ Varicose Veins
- ☐ Shortness of Breath

GENITO-URINARY

- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control

MUSCULOSKELTAL

- ☐ Joint Pains
- ☐ Paralysis/Weakness
- ☐ Muscular Pain
- ☐ Fractures
- ☐ Herniated Discs

EYE, EAR, NOSE, THROAT

- ☐ Persistent Cough
- ☐ Ringing in the Ears
- ☐ Sinus Problems

SCREENINGS

Date of last Pap Smear: _____

Have you had a Colonoscopy: ☐ YES ☐ NO

If yes, date of last Colonoscopy: _____

Have you had a Mammogram? ☐ YES ☐ NO

If yes, date of last Mammogram _____

Have you had an Upper Endoscopy? ☐ YES ☐ NO

If yes, date of last Upper Endoscopy: _____

CONDITIONS: Check conditions you have now or had in the past

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cataracts
- ☐ Cancer
- ☐ Drug Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Infectious Disease
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Disease
- ☐ Psychiatric Care
- ☐ Rheumatoid Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other _____

FAMILY HISTORY: List all medical history pertaining to each family member

MOTHER: _____ FATHER: _____

MATERNAL GRANDPARENTS: _____ PATERNAL GRANDPARENTS: _____

SIBLINGS: _____

Have you ever have a blood transfusion? ☐ YES ☐ NO If yes, please give approximate date(s) _____

(PLEASE TURN OVER)

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Hernia Institute Cancer Center Gastrointestinal Center

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NEW YORK SURGICAL PARTNERS

Today's Date: _____

Name: _____ Date of Birth: _____

LAST FIRST

MEDICATIONS: Including Vitamins and Herbal Medications

Medication	Dose	Frequency

ALLERGIES: List allergies to medication(s) or substances(s) Describe your allergic reaction

Allergy	Reaction

HOSPITALIZATIONS/SURGERIES:

Year	Reason for Hospitalization / Surgery	Hospital Name

HEALTH HABITS: Fill out all that apply

Substance	How Much	How Often	Date of Last Use
Caffeine			
Tobacco			
Recreational Drugs			
Alcohol			

I Certify that the above information is correct to the best of my knowledge. I will not hold my Physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of these forms

_____ Patient / Representative Signature

_____ Print Name / Relationship

_____ Date

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Last Four (4) Digits of SS#
Patient Address	Phone Number	MR#

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* INFORMATION** only if I place my initials on the appropriate line in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
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.

FOR OFFICE USE ONLY Boxes 6-12

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

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

8. Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record include: (indicate by Initialing)

☐ Other: _____ _____ Alcohol/Drug Treatment

_____ HIV Related Information

_____ Mental Health Information

9. Reason for release of information:
☐ Persona Use ☐ Medical Care ☐ Attorney
☐ Insurance ☐ Other

10. This authorization will expire within 1 year of the signature date unless specified:

11. If not the patient, name of person signing form:

12. 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.

X _____ _____ _____

Signature of Patient or Representative authorized by law | Date | Time

A COPY of this Authorization shall have the same force and effect as an original

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

Catholic
Health Services
of Long Island
At the heart of health

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. CHS Physician Partners, P.C. may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit CHS Physician Partners, P.C. to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

_____ _____
(relationship to me)

_____ _____
(relationship to me)

_____ _____
(relationship to me)

_____ _____
(relationship to me)

_____ _____
(relationship to me)

I expressly permit CHS Physician Partners, P.C. to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel.#: _____

Office voicemail: Tel.#: _____

Other (specify): _____ Tel.#: _____

☒ _____ _____

Signature of Patient
Personal Representative
Parent/Guardian

(Date)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the end of this notice, and how I may obtain access to and control this information.

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date / Time

_____

Description of Personal Representative's Authority

_____

Signature of Facility Representative Date / Time

Catholic Health Services of Long Island

Patient Authorization, Assignment of Benefits & Financial Agreement

PATIENT NAME (PRINT):	DATE OF BIRTH:	EFFECTIVE DATE:

I acknowledge and understand that by signing below, I hereby authorize payment directly to New York Surgical Partners - 2200 Northern Blvd, Suite 125, East Hills, NY 11548 - Telephone: 516-627-5262 Fax: 516-627-0641 for services rendered to me, as specified more fully below.

1. **MEDICARE:**
   - I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.
   - I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.
   - I authorize the release of medical information necessary to complete any insurance claim forms and to pay the claim.
   - The Practice accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible and/or coinsurance payment and payment for any non-covered services. Coinsurance and deductibles for covered services will be based upon the charge determination of the Medicare carrier.
   - I authorize the release of my information to any MediGap or other health insurance carrier I maintain and authorize payment of these secondary insurance benefits to be made on my behalf to the Practice, if possible.
   - My authorization will remain in effect unless I revoke my authorization in writing.

2. **OTHER INSURANCE PLAN PARTICIPATION:** The Practice maintains a list of its contracts with health care service plans ("Plans"), which identifies the Practice physicians who participate in each Plan. A copy of the current list is available from the Practice at the address, telephone number and/or website listed above.
   - I have been informed whether any services rendered to me by the Practice may be provided by a non-participating provider and, if so, (i) that such services by a non-participating provider may result in costs not covered by the Plan and (ii) I am individually obligated to pay the full charges for all such services.
   - I understand that the Practice has no contract, expressed or implied, with any Plan that does not appear on the list.
   - I have been informed that I am individually obligated to pay the full charges for all services rendered to me by the Practice if my Plan does not appear on the list of Plans maintained by the Practice.

3. **NON-COVERED SERVICES**: I understand that each Plan (*i.e.*, HMOs, PPOs) defines what items and services are covered and what items and services are not covered by the Plan.
   - I understand that I will receive an Advanced Beneficiary Notice ("ABN") from the Practice for services that are not or may not be covered by my Plan, and that I will be given the option to accept or decline any non-covered services.
   - I accept full financial responsibility for payment for any potentially non-covered services that I have accepted, as reflected on the ABN, if my Plan determines that such service is not covered. Examples of non-covered services include, but are not limited to, services not specified as being covered by a Plan, services not listed in the benefit summary furnished to patients by the Plan, and/or treatment or tests not authorized by the Plan.
   - I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.

4. **RELEASE OF INFORMATION**:
   - I understand that the Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, (1) to any person or corporation that is or may be liable or under contract to the Practice for reimbursement for services rendered, and/or (2) to any health care provider for continued patient care.
   - I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical science, medical education, medical research, and/or for the collection of statistical data or pursuant to State or Federal law.

5. **FINANCIAL AGREEMENT**:
   - In return for the services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.
   - If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.
   - If my account is delinquent, I may be charged interest at the legal rate. I assign to the Practice any benefits of any type under any policy of insurance that insures me or any other party liable to me.
   - If my insurance company or Plan designates copayments and/or deductibles, I will pay such copayment and/or deductible amounts to the Practice.
   - ***I agree to be primarily responsible for the payment of the Practice's bill.***

Beneficiary Signature or Authorized Party _____ Date _____

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PHYSICIANS PARTICIPATING IN YOUR CARE

Patient Name: _____ **Date:** _____ **Date of Birth:** _____

Please complete all that apply:

TYPE	PHYSICIAN NAME		TELEPHONE NUMBER	OFFICE ADDRESS
	FIRST	LAST		
Primary Care Physician				
Cardiologist				
Gastroenterologist				
Pulmonologist				
Hematologist/Oncologist				
Endocrinologist				
Nephrologist				
Any other specialist(s)				

Name of the physician that referred you to our office: _____

Please provide your pharmacy information:

Name of Pharmacy: _____

Phone number: _____

Addres: _____

MY CHART ACTIVATION FORM

USER NAME (6 CHARCTERS) MUST CONTAIN ONE UPPERCASE LETTER AND MAY CONTAIN ONE NUMBER AND/OR SPECIAL CHARACTER

_____

PASSWORD (8 CHARACTERS) *MUST CONTAIN ONE UPPERCASE AND ONE NUMBER AND ONE SPECIAL CHARACTER*

_____

BIRTHDATE _____

EMAIL ADDRESS: _____

CHOOSE ONE:

NAME OF YOUR FIRST PET: _____

FAVORITE PERSON FROM HISTORY: _____

MAKE OF YOUR FIRST CAR: _____

CLOSEST CHILDHOOD FRIEND: _____

https://mychart.chsli.org

Catholic
Health Services
of Long Island
At the heart of health

CATHOLIC HEALTH SERVICES OF LONG ISLAND
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

This Notice of Privacy Practices (Notice) describes how Catholic Health Services of Long Island and the entities and providers affiliated with our healthcare system (collectively, "CHS") will use information about you and when CHS can share your information with others. We are required by law to maintain the privacy of your Protected Health Information, or "PHI", which is any health information that identifies you (such as your name, address and date of birth, and any information created by your healthcare providers for treatment, billing or payment). We are providing this Notice to you to help you understand your rights and your choices as a patient, our uses and disclosures of your PHI, and our responsibilities as your healthcare provider. We are required to abide by the terms of this Notice.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the privacy policies of the CHS entities (including our hospitals, nursing homes, physician practices, home care and hospice programs and the other CHS-affiliated entities and providers). This includes CHS employees, students, volunteers and business associates as well as independent health care providers not employed by CHS who are involved in your care while practicing in one of more of our facilities.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

I. **Standard Uses and Disclosures**: CHS can use and share your health information without your prior authorization to provide you with medical treatment or services, to allow us to receive payment for those services, and to conduct our daily healthcare operations.

   A. **Treatment**: We can use and share your PHI to provide you with treatment and/or other services. We can contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, and can share your PHI with other providers (*e.g.*, physicians, nurses, pharmacists and other healthcare facilities) involved in your treatment.

   B. **Payment**: We can use and share your PHI to be paid for the services that we have provided to you—for example, we can request payment from your health insurer and can verify that your health insurer will pay for your healthcare services.

   C. **Business Operations**: We can use your health information or share it with others to conduct our business operations—for example, we can share your health information with others to evaluate the performance of the staff who have cared for you or implement improvements to the care we provided to you.

   D. **Business Associates**: We can share your PHI with our "business associates," or the individuals and companies we have engaged to create, maintain, receive or transmit your PHI to perform certain business functions for us. For example, we can use another company to perform billing services on our behalf. Our business associates are required by law to maintain the privacy and confidentiality of your PHI.

II. **Uses and Disclosures That Do Not Require Your Consent**: CHS can also share your health information without your permission in the following circumstances:

A. **Public Health Activities**: We can disclose your PHI to authorized public health officials for the following public health activities:

- Reporting births or deaths;
- Reporting adverse reactions to medications;
- Preventing or controlling disease, injury or disability;
- Alerting a person who may have been exposed to an infectious disease or may be at risk of contracting or spreading a disease;
- Assisting in product recalls;
- Reporting information to your employer to comply with laws that govern work-related illnesses and injuries, or workplace medical surveillance.

B. **Victims of Abuse, Neglect or Domestic Violence**: If we reasonably believe you are a victim of abuse, neglect or domestic violence, we must disclose your PHI to a government authority authorized by law to receive such reports.

C. **Health Oversight Activities**: We can disclose your PHI to any government agencies authorized to conduct audits, investigations and inspections of our CHS entities. These agencies monitor the operations of CHS to determine our compliance with applicable healthcare laws and regulations pertaining to government benefit programs (such as Medicare and Medicaid).

D. **Public Safety**: We can use or disclose your PHI to prevent or lessen a serious and imminent threat to your health and safety, and the safety of others and the public at large.

E. **Workers' Compensation**: We can disclose your PHI as authorized by state laws relating to workers' compensation or similar government programs.

F. **Organ and Tissue Donation**: We can disclose your PHI to organizations that procure organs and other tissues for banking and/or transplantation.

G. **Deceased Persons**: We can disclose the PHI of deceased individuals to a coroner, medical examiner or funeral director authorized by law to receive such information.

H. **National Security**: We can disclose your PHI to authorized federal officials who are conducting intelligence, counter-intelligence or other national security activities.

I. **Legal Proceedings**: We can disclose your PHI in response to a court order or subpoena in a judicial or administrative proceeding.

J. **Law Enforcement**: We can disclose your PHI to law enforcement officials in the following situations:

- When required by law;
- For purposes of identifying and locating a suspect, fugitive, witness or missing person.
- If you are suspected to be the victim of a crime.
- To report a suspicious death resulting from criminal conduct.
- To report suspected criminal conduct occurring on our property.
- In an emergency situation.

K. **Prison Inmates**: We can disclose the PHI of inmates to the correctional facilities housing them for

purposes of providing the inmate with healthcare, to protect the health and safety of the inmate or the health and safety of others, and/or for the safety and security of the correctional facility.

L. **Military Command Authorities**: If you are a member of the armed forces, we can disclose your PHI as required by the appropriate military command authorities.

M. **Proof of Immunization**: We can disclose proof of immunization about a child to a student's or prospective student's school, as required by State or other law, if a parent, guardian, or other person acting in loco parentis, or an emancipated minor, authorizes us to do so.

N. **Research**: We can use or disclose your PHI for research purposes, subject to the requirements of applicable law. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

O. **As Required by Law**: We can use or disclose your PHI when we are required to do so by any other laws not already referenced above.

Note: Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

III. **Uses & Disclosures That We May Make Unless You Object**: In some situations, you may have the opportunity to agree or object to the sharing of your information. While a written authorization is not required in the following circumstances, we can share your information unless you instruct us otherwise:

A. **Patient Directory**: Each of our facilities will include your name, room number, general health condition and religious affiliation in its Patient Directory while you are an inpatient. Unless you object, we can share your Patient Directory information with anyone who asks for you by name (either in person or via telephone). If you do not wish to have your information listed in the hospital directory, you must notify hospital staff during registration.

B. **Disclosure to Family, Friends or Caregivers**: We can share your health information with any your family members, relatives or close friends who may be involved in your care, or who may be responsible for paying for your care. We will always give you an opportunity to object to these disclosures. If we provide your information to these individuals, it will only be information directly relevant to their involvement in your care. We can also disclose your PHI to your family or close friends in the event of an emergency or to notify (or assist in notifying) them of your location, general condition or death.

C. **Fundraising**: We can use your PHI to support our business operations. For example, we may use the dates on which you received treatment or the department in which you were seen to contact you about participating in fundraising activities. Any fundraising communication you receive will provide instructions on how to opt out of receiving future fundraising inquiries.

D. **Health Information Exchanges**: CHS participates in certain electronic health information exchanges ("HIEs"), including Epic's "Care Everywhere" and "Healthix." These HIEs generally allow patient PHI to be shared electronically through secured connected networks and permit all healthcare providers that participate in the HIE to have immediate electronic access to your pertinent medical information for treatment, payment and healthcare operations purposes. To the extent permitted by law, you may either opt out or deny the consent to have your health information made available through Epic's Care Everywhere, Healthix, or any other HIEs utilized by the CHS facilities by contacting the CHS Privacy Officer. Please refer to the CHS internet site (www.chsli.org) for a

list of the CHS Privacy Officers.

E. **Disaster Relief**: We can disclose your PHI to disaster relief organizations so they can contact your family or friends or coordinate disaster relief efforts.

IV. **Uses and Disclosures Requiring Your Specific Written Authorization**: Your consent is required for certain uses and disclosures of your PHI. In the following circumstances, we can disclose your information ***only with*** your written authorization:

A. **Marketing**: We cannot sell your PHI for marketing purposes.

B. **Sale of PHI**: We cannot sell your PHI.

C. **Sensitive PHI**: We cannot share certain highly confidential health information. Except in limited circumstances, we must obtain your written authorization to release the following types of information:
- Psychotherapy notes
- Information related to mental health treatment
- Information related to drug and alcohol abuse/treatment
- HIV status and other sexually transmitted diseases
- Information involving genetic testing and other genetic-related information.

Note: Other uses and disclosures of your protected health information not described above in this Notice or permitted by law will be made only with your written authorization.

YOUR HEALTH INFORMATION RIGHTS

When it comes to your Protected Health Information, you (or your personal representative acting on your behalf) have certain rights to access and control your health information. This section explains your rights and how to exercise them.

A. **Inspecting and Obtaining Copies of Your Medical Records**: You have the right to inspect and/or receive paper or electronic copies of your medical and billing records.

- Written Request: You must submit your request in writing by completing the "Authorization for the Use & Disclosure of PHI" form located on the CHS internet site (www.chsli.org).

- Sending the Record Request: You must submit your written request directly to the specific CHS entity that treated you.

  ❖ CHS Hospitals, Nursing Homes, Home Care, Hospice and Maryhaven: To obtain your medical record from a CHS hospital, nursing home, home care or hospice service or any Maryhaven program, please submit the "Authorization for the Use & Disclosure of PHI" form to the Health Information Management (HIM) Department of the specific CHS entity that treated you. Please refer to the CHS internet site for the contact information of each HIM Department (www.chsli.org).

  ❖ CHS Physician Practices: To obtain your medical record from a CHS physician practice, please submit the "Authorization for the Use & Disclosure of PHI" form directly to the physician practice.

- Fees: We can charge you a reasonable cost-based fee for the labor associated with providing you with access to your medical and billing records. Under New York State law, this fee may not exceed $0.75 per page.

- Form/Format: If your PHI is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document.

- Response Time: We will provide you with a copy or a summary of your health information, usually within 30 days of your written request.

- Denial of Access: CHS has the right to deny access to your PHI. If your request is denied, we will provide you with a timely written explanation for the basis of the denial.

- Revoking Authorization: If you provide us with a written authorization, you can revoke that written authorization at any time (unless we receive your revocation after we have already relied upon your written authorization). To revoke a written authorization, please contact the specific CHS entity that treated you (*e.g.*, the HIM Department of a facility or the physician practice).

- Billing Information: To obtain a paper or electronic copy of your billing information, please submit your request in writing to the Director of Patient Accounts, CHS Service Center, 245 Old Country Road, Melville, New York 11747.

B. **Requesting an Amendment to Your Medical Record**: You have the right to request an amendment to your medical record (as maintained by CHS) if you believe that your information is incorrect or incomplete.

- You must submit your written request to the specific CHS entity that treated you (e.g., to the HIM Department of a facility or to the physician practice). All requests should use the "Patient Request for Amendment of Records Form," which can be found on the CHS internet site (www.chsli.org).

- The written request should detail what part of the record you want changed and the reasons why you are requesting the change.

- CHS can deny your request if we reasonably believe that the information is accurate and complete, if we did not create the PHI, or if other special circumstances apply. CHS will notify you in writing of any denial of your request within 60 days.

C. **Requesting an Accounting of Disclosures of your Health Information**: You have the right to request an accounting of certain disclosures of your PHI by CHS.

- The "Accounting of Disclosures" will list the number of times CHS has disclosed your PHI in the past six (6 years), the individual or company who received your PHI, and why your PHI was shared. However, any disclosures of your PHI made when our facilities were providing care for you or seeking payment for your health services, or when you authorized the disclosure in writing, will not be included on this list.

- You must submit a written request to the specific CHS entity that treated you (*e.g.*, the HIM Department of a facility or the physician practice). All written requests should be sent with the "Accounting of Disclosure Form," which can be found on the CHS internet site (www.chsli.org).

- CHS will provide you with one Accounting of Disclosures for free each year, but will charge a

reasonable, cost-based fee if you ask for more than one Accounting of Disclosures within a 12-month period.

D. **Requesting Confidential Communications Methods**: You have the right to receive your health information through a reasonable alternative means (home or office phone) or at an alternative location (a different address), and you can revoke any such request at any time. CHS will accommodate all reasonable requests. Written requests for alternate communication methods should be directed to the Privacy Officer of the CHS facility or physician practice that treated you. Please refer to the CHS internet site (www.chsli.org) for list of the CHS Privacy Officers.

E. **Requesting Additional Privacy Protections**: You have the right to request certain restrictions on how we use or share your PHI to treat you, collect payment from you (or your insurer) or to conduct our health care operations. For example, you can limit how your information is shared with certain family and friends. We are not required to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you emergency treatment.

- You should submit your written request to the Privacy Officer of the CHS facility or physician practice that treated you. Please refer to the CHS internet site (www.chsli.org) for list of the CHS Privacy Officers.

- You have the right to restrict the disclosure of your medical information to your health plan (and not have a claim submitted to the health plan for services we have provided to you) when you submit written request to us and pay for the service in full on an "out-of-pocket" basis prior to or at the time of service. We will comply with your request unless the disclosure to your health plan is required by law.

F. **Notification Following a Breach of Unsecured Protected Health Information**: You have the right to receive a written notification from us in the event that there is a breach of your unsecured PHI. The HIPAA Privacy rule requires us to provide you with a breach notification within 60 days of discovery.

G. **Obtaining a Paper Copy of this Notice:** You have the right to receive a paper copy of this Notice from us at any time (even if you have previously agreed to accept this Notice electronically). You may also view or obtain an electronic copy of this Notice on our intranet site (www.chsli.org).

H. **Change in this Notice**: We reserve the right to change the terms of this Notice. If we make any changes, the changes will apply to all of your information in our records. The new notice will be available to you upon request, in the office of the CHS entity where you receive treatment, and on our website (www.chsli.org).

I. **How Someone May Act on Your Behalf**: You have the right to identify a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors (unless the minors are permitted by law to act on their own behalf).

J. **Reporting a Privacy Concern:** CHS takes the privacy and security of your PHI very seriously. If you believe your privacy rights have been violated, please visit the CHS internet site for the contact information of the CHS Privacy Officer (www.chsli.org). You can also call the CHS Compliance Helpline at (866) 272-0004 to make a confidential or anonymous report. Any concerns about the privacy and security or your PHI reported to the Helpline will be directed to the Privacy Officer of the specific CHS entity that treated you. *No one will retaliate or take action against you for filing a complaint or reporting information to the Helpline.* You can also file a complaint with the U.S.

Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington, DC 20201, by calling (877) 696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

K. **CHS Affiliated Entities Covered by this Notice**:

This Notice applies to the following CHS entities:

Advanced Rehabilitation Medicine, PLLC
Breast Cancer Help, Inc.
Cardiac EKG Interpretations, PC
CHS Physician Partners IPA, LLC
CHS Physician Partners, PC
Good Samaritan Hospital Medical Center
Good Samaritan Nursing Home
Good Shepherd Hospice
Maryhaven Center of Hope
Mercy Internal Medicine, PC
Mercy Medical Center
Nursing Sisters Home Care, Inc. d/b/a Catholic Home Care
Our Lady of Consolation Nursing and Rehabilitative Care Center
Samaritan Emergency Medical Services PC
Samaritan Medical Services, PC
Samaritan Pediatric Services, PC
Southwest Suffolk Medical, PC
St. Francis Cardiac Prevention Services, PC
St. Catherine of Siena Medical Center
St. Catherine of Siena Nursing and Rehabilitation Care Center
St. Charles Hospital
St. Francis Cardiovascular Physicians, PC
St. Francis Hospital – The Heart Center®
Suffolk Hearing & Speech Center, Inc.
WSNCHS North, Inc. d/b/a St. Joseph Hospital

[1] Indicates a facility that is a department of Good Samaritan Hospital Medical Center

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Effective Date: August 1, 2019