

Mount Sinai Doctors

Fax

Date: 7/24/14

Faculty Practice

To: Leslie

Phone: [Redacted]

Fax: [Redacted]

Pages: 6

Re: J. Epstein

From: Dr. DiFabrizio/Imani/Annette

Pulmonary, Critical Care and Sleep Medicine

Phone: [Redacted]

Fax: [Redacted]

- Urgent
- For Review
- Please Comment
- Please Reply
- Please Recycle

Notes: Please FAX a copy of insurance card & ID along with completed forms.

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Mount Sinai Doctors Faculty Practice

CONSENT FOR COMMUNICATION VIA E-MAIL (Provider-Patient)

I, _____, hereby consent to have my physician, _____, communicate with me or members of his/her staff, where appropriate or other physicians, nurse practitioners and pharmacists via e-mail regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of his/her office staff, or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail.

E-mail: _____

Signature: _____ Date: _____



The Mount Sinai Medical Center

One Gustave L. Levy Place
New York, NY 10029-6574

The Mount Sinai Hospital
Mount Sinai School of Medicine

Mt. Sinai Medical Center Department of Medicine FPA Practice

Patient Responsibility and Assignment of Benefits

In consideration of medical care and services rendered to me, I agree that my responsibilities to (provider) _____ of the Department of Medicine include but are not limited to the following:

- Obtaining all necessary referrals from my Primary Care physician for visit(s) to specialists.
- Obtaining all necessary pre-authorizations for procedures to be performed by the specialist.
- Payment of co-payments and deductibles not paid by my insurance plan.
- Payment for services not covered by my insurance plan.
- Informing the office of any change in my insurance coverage.

Medicare Beneficiaries:

- I hereby authorize the release of medical and/or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers (including information relating to mental illness and/or AIDS/ARC/HIV) necessary for this or any related Medicare claim.

All Patients:

- I hereby authorize the release of medical and/or other information about me that is necessary for the processing of my insurance benefits.
- I hereby authorize payment on my behalf.
- I hereby assign benefits payable to (provider) _____

I have read, understand and agree with the above.

Name of Patient

Date

Signature of Patient or Authorized Representative

Date

Relationship to Patient

Date





Mount Sinai Doctors Faculty Practice

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

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 hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

Patient Name _____

Signature of Patient or Personal Representative _____

Print Name of Patient or Personal Representative _____

Date _____

Description of Personal Representative Authority _____

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because: _____

- The patient refused to sign despite good faith efforts
- The patient was unaccompanied and not alert and oriented
- The patient was unaccompanied and needed emergency care
- Other, (explain): _____

Employee Signature: _____ Employee Title: _____

Print Name: _____ Date: _____

Acknowledgement subsequently obtained, (see above).

MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires health care providers to obtain your written authorization prior to contacting you with marketing information or about philanthropic initiatives that support the work of your doctors. Your permission for disclosure of your name will allow Mount Sinai staff to contact you about marketing or philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed - that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Mount Sinai Development Office at (212) 659-8500.

Thank you.

I authorize any doctor employed by or on the staff of The Mount Sinai Hospital and Mount Sinai School of Medicine ("Mount Sinai") to disclose my name and contact information to Mount Sinai development and public affairs staff for the purpose of contacting me about Mount Sinai marketing and philanthropy opportunities. I understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third parties for any purpose other than that expressed above. This authorization will remain in effect for five years. However, I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

X _____ X _____ X _____
Signature of Patient Print Name of Patient Date
or Personal Representative/Guardian or Personal Representative/Guardian

X _____
Address of Patient

If Applicable, Description of Authority of Personal Representative/Guardian

A signed copy of this form is available upon request by patient or patient representative

MOUNT SINAI HEALTH INFORMATION EXCHANGE AND HEALTHIX CONSENT FORM

The Mount Sinai Health Information Exchange ("Mount Sinai HIE") and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology ("Health IT"). To learn more about Health IT in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

In this Consent Form, you can choose whether to allow the health care providers listed on the Mount Sinai HIE website www.mountsinaiconnect.org ("HIE Participants") to obtain access to your medical records through a computer network operated by the Mount Sinai HIE. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you. The list of HIE Participants on the website will be updated regularly.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of The Mount Sinai Hospital and Icahn School of Medicine at Mount Sinai (together, "Mount Sinai") to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization ("RHIO"), a not-for-profit organization recognized by the State of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent gives your permission for any Mount Sinai program in which you are a patient to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at <http://www.healthix.org> or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES OR HEALTH INSURANCE COVERAGE.

PLEASE CAREFULLY READ THE INFORMATION ON THE ATTACHED FACT SHEET, WHICH IS PART OF THIS CONSENT FORM, BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 of 2:

- 1. I GIVE CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access ALL of my electronic health information through the Mount Sinai HIE and I GIVE CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.
- 2. I DENY CONSENT to ALL of the HIE Participants listed on the Mount Sinai HIE website to access my electronic health information through the Mount Sinai HIE and I DENY CONSENT to ALL employees, agents and members of the medical staff of Mount Sinai to access ANY of my electronic health information through HEALTHIX for any purpose, even in a medical emergency.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows health care providers treating you in an emergency to gain access to your medical records, including records that are available through the Mount Sinai HIE and Healthix. IF YOU DON'T MAKE A CHOICE, the records will only be shared in an emergency as allowed by applicable law.

Print Name of Patient

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)