Maimonides Medical Center

OUTSIDE PRE-EMPLOYMENT PHYSICAL INFORMATION	
DOCUMENTS	**SENT**
Pre-employment Questionnaire	
Pre-employment Physical Examination Form	
PPD	
BHIX Signed Consent Form	
Vaccination Records with RANGES-As listed on Page 2 of the PDF	
Hepatitis B/ Influenza History and Attestation	
Documentation of TDAP Vaccine- Please make sure to submit **TDAP, not TD**	

Please note:

- Everyone **MUST** schedule an appointment at Employee Health for Color Vision Screening and FIT Testing (this is not exercise, we are referring to the respiratory masks for seeing patients in isolation. FIT testing must be done here at Maimonides. Different hospitals have different masks)
- **ANYONE NOT CLEARED** by the July 1st start date will not be allowed on floors, and will be unable to have patient contact. We do not receive clearance forms from Employee Health until they have all information on a new hire. **THIS INCLUDES FIT TESTING.**
- Lab Results must include Titers with ranges for
  - Mumps
  - Rubella
  - Hepatitis B- HepBsAb, & HepBsAg
  - Measles
  - Varicella

- Documentation of TDAP- (tetanus, diphtheria and acellular pertussis)

Maimonides Medical Center

Employee Health Services

5008 Fort Hamilton Parkway - Brooklyn, NY 11219 (p) 718-283-8978 (f) 718-635-8949

Requirements for Pre-Employment Physicals Completed outside of Maimonides EHS

- Completion of Medical History Form
- Completion of Physical Examination- Completed and signed by a Licensed Provider including their license number.
- Submission of lab reports have to be attached showing titer results for: Measles, Mumps, Rubella, Varicella, HepBsAb, & HepBsAg.
    - The document must be prepared by a physician, physician's assistant, nurse practitioner or a laboratory, demonstrating serological evidence of antibodies which indicates immunity.
- Completion of Hepatitis B/ Influenza History /Attestation

All Prospective employees must complete the following at EHS:

- If you are PPD positive by history you must complete a chest X-ray prior to employment.
  We will also accept Quanti-Feron TB Gold (QTb-G) in lieu of a TST
- As noted above if you do not have the required documentation for the required titers your blood must be drawn prior to employment.
- You must be fit tested for a respirator.
- Color vision screening.
- Certain categories of employees require additional testing which must be done at EHS.

Maimonides

MEDICAL CENTER

PERSONNEL HEALTH SERVICES

PRE-EMPLOYMENT QUESTIONNAIRE

NAME	DATE OF BIRTH
ADDRESS	
TELEPHONE NO:	

OTHER EMPLOYMENT	POSITION	DEPARTMENT

DO YOU HAVE ANY OF THE FOLLOWING:	NO	YES	EXPLAIN
REACTIONS TO MEDICINES			
REACTIONS TO CHEMICALS			
SKIN RASHES OR ECZEMA			
FREQUENT DIARRHEA			
HERNIA			
HAVE YOU EVER HAD	**NO**	**YES**	
ASTHMA			
HAY FEVER			
BRONCHITIS			
SHORTNESS OF BREATH WHILE WALKING			
TIGHTNESS OF CHEST			
EMPHYSEMA			
PPD PLANTED			WHEN _____ WHAT WAS THE RESULT
HIGH BLOOD PRESSURE			
HEART TROUBLE			
HEART ATTACK			
SWELLING OF THE ANKLES			
FAINTING SPELLS			
VARICOSE VEINS			
EPILEPSY			
DOUBLE VISION			
NUMBNESS OF HANDS, FEET			
SEVERE HEADACHES			
DIZZY SPELLS			
NERVOUS BREAKDOWN			
BLOOD IN URINE OR STOOL			
KIDNEY TROUBLE			
DIABETES OR SUGAR IN URINE			
THYROID TROUBLE OR GOITER			
HEPATITIS OR JAUNDICE			
SYPHILIS OR GONORRHEA			
ANEMIA			
RHEUMATISM OR ARTHRITIS			
BACK PAIN			
BACK INJURY			
SWOLLEN JOINTS			
DISLOCATED SHOULDER			
ABDOMINAL PAINS			
SURGERY			WHEN _____ WHAT KIND

NAME ALL MEDICATIONS YOU TAKE REGULARLY

WRITE "NONE" IF YOU DON'T TAKE ANY

ARE YOU ALLERGIC TO ANY MEDICATIONS		NO	YES	NAME OF MEDICATION			

HAVE YOU EVER HAD	DISEASE		VACCINE		DATE
	NO	YES	NO	YES	
CHICKEN POX (VARICELLA)					
MEASLES (RUBEOLA)					
MUMPS					
RUBELLA (GERMAN MEASLES)					

DO YOU RECEIVE ANNUAL	NO	YES	DATE OF LAST VACCINE
INFLUENZA VACCINE			

IF NO, WHY

- ☐ Perceived ineffectiveness of vaccine
- ☐ Medical contraindication (incl. Pregnancy)
- ☐ Insufficient time or inconvenient
- ☐ Perceived low likelihood of contracting influenza
- ☐ Avoidance of medications
- ☐ Fear of needles
- ☐ Reliance on treatment with homeopathic medications
- ☐ Egg Allergy
- ☐ Other: (please specify) _____

	NO	YES	
DO YOU SMOKE			HOW MANY PACKS/DAY
			HOW LONG/YEARS
DO YOU DRINK ALCOHOL			IF YES, HOW OFTEN

FEMALES ONLY

HOW MANY MISCARRIAGES HAVE YOU HAD?

ARE YOU PREGNANT NOW?

I certify that all of the statements on both sides of this questionnaire are true and may be investigated and if found to be false will constitute sufficient reason for my dismissal. I understand that employment is contingent upon taking and passing a physical examination which includes drug testing.

_____ _____

Signature Date

Maimonides Medical Center

Maimonides Medical Center

Employee Health Services

5008 Fort Hamilton Parkway - Brooklyn , NY 11219 718-283-8978

PRE-EMPLOYMENT PHYSICAL EXAMINATION

Must be completed and signed by a licensed provider

Name: _____ DOB:_____

BP	**Pulse**	**Respirations**
Height	**Weight**	
EYES		
ENT		
NECK		
LUNGS		
HEART		
ABDOMEN		
NEUROLOGICAL		
EXTREMITIES		
OTHER		

I have determined that the Individual identified on this document is free from any health impairment that may be of potential risk to patients or may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Examining Provider Signature	**Date**
Print Name	**License Number**
Examining Provider's Address	

Maimonides Medical Center

Department of Human Resources

Employee Health Services

5008 Fort Hamilton Parkway - Brooklyn, NY 11219 (p) 718-283-8978 (f) 718-635-8949

PPD FORM

Re: _____ Life #_____
(NAME)

Circle one: Employee/Resident Volunteer MMC Holding Voluntary Physician

---

PPD was planted on _____ on RIGHT (forearm) LEFT (forearm)
(date) Circle

PPD to be read in 48-72 Hrs

Reading Results: ***PLEASE DO NOT LEAVE ANY BLANKS*** DATE: _____

Erythema _____mm's (if zero write 0x0)

Induration _____ mm's (if zero write 0x0)

Please circle reading: NEGATIVE POSITIVE

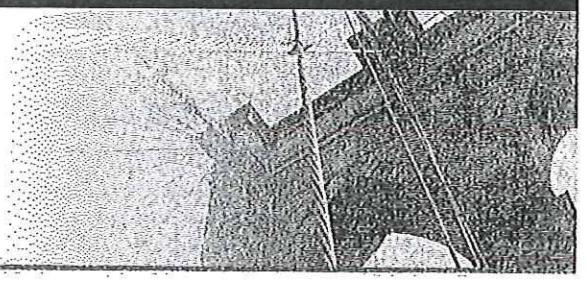
Please PRINT Name: _____

Please sign here: _____ MD, NP, RN or PA Date: _____
(Circle)

Please write your license # or Life #: _____

BHIX Brooklyn Health Information Exchange

Patient Educational Fact Sheet



About Health Information Exchange

You probably receive medical care from a variety of providers, including hospitals, clinics, nursing homes and home care agencies. Each provider keeps its own medical record about you, including information about which medicines you use and which tests you have had.

If your health care providers can share this information with one another, they can provide you with better care — especially in an emergency. Giving providers involved in your care a better picture of your medical history, prior treatments, test results, and allergies helps them make the most accurate diagnosis and provide the best treatment.

About Brooklyn Health Information Exchange (BHIX)

BHIX is a not-for-profit organization connecting healthcare providers-including hospitals, nursing homes, home health agencies, pharmacies and clinical laboratories-throughout Brooklyn.

BHIX's secure computer system helps your doctors, nurses and other health care professionals access your health information. Providers who use BHIX can provide you with better treatment and improve the quality of medical care they deliver to all patients.

Please review this Brochure carefully to help decide if you wish to give permission for any of the BHIX Participating Provider Organizations ("Participating Providers") to access your medical information through BHIX.

How BHIX Improves Care

BHIX's vision is to improve the quality, efficiency, and safety of care by making more timely health care information available to your providers.

Quality: With more complete, up-to-date information available, your physicians will be better able to provide you with the right treatments and services. Increased clinical information helps to support improvement in care coordination and disease management and allows Participating Providers to improve the quality of care delivered to all patients.

Efficiency: Since your physicians will be able to view health reports from other facilities, you may not have to take the same tests again. You may also not need to repeat giving drug and medical information to multiple Participating Providers.

Safety: Your medication history will be included in BHIX, so your physicians will be able to make better decisions and prevent errors in prescribing medicines and other treatments for you.

What Information will be Accessed

Health Information Sources: Information accessed through BHIX comes from a variety of Health Information Sources. These Health Information Sources may include Participating Providers, other health care providers (such as pharmacies and clinical laboratories), health insurers, the New York State Medicaid program and other health information exchanges. A complete list of current Health Information Sources may be found at www.bhix.org. This list will change from time-to-time as BHIX continues to grow.

Types of Information: Information accessed through BHIX includes ALL of your medical information, including but not limited to, sensitive information related to HIV/AIDS, mental health, genetic disease or tests, alcohol or drug abuse, sexually transmitted diseases and family planning.

About Your Right to Control Access

As a patient, you have the right to control whether any Participating Provider can access your medical information. Each Participating Provider involved in your care must obtain your Consent separately to access your medical information through BHIX. The decision to participate in BHIX is voluntary. No Participating Provider will deny you medical care and your insurance eligibility will not be affected if you do not participate in BHIX.

BHIX Patient Consent Form

Give Consent: In order to allow your Participating Provider to access your medical information through BHIX, please indicate that you Give Consent on a BHIX Patient Consent Form and return this form to your Participating Provider at your next visit. If you consent, only individuals involved in giving or improving the quality of medical care and authorized by your Participating Provider to use BHIX will be able to access your medical information.

Deny Consent: If you do not want to allow your Participating Provider to access your medical information through BHIX — *even in an emergency* — please indicate that you Deny Consent on a BHIX Patient Consent Form and return this form to your Participating Provider at your next visit.

A copy of the BHIX Patient Consent Form can be found at www.bhix.org or obtained at your Participating Provider.

BHIX Withdrawl of Consent Form

Withdrawal of Consent: If you wish to change your mind and Withdraw Consent for your Participating Provider to routinely access your medical information through BHIX, please complete a BHIX Withdrawal of Consent Form and return it to your Participating Provider at your next visit or give it to your Participating Provider's Privacy Officer. A copy of this form can be found at www.bhix.org or obtained at your Participating Provider.

Important Note about Emergencies

If you Deny Consent using the BHIX Patient Consent Form, your Participating Provider will not be able access your medical information through BHIX — *even in an emergency.*

How BHIX Protects the Privacy and Confidentiality of Your Information

Participating Providers follow New York State and Federal privacy and confidentiality laws. Participating Providers are permitted to look at your health information through BHIX only if they are involved in giving you care or improving the quality of medical care they deliver to their patients. BHIX maintains safeguards to prevent your medical information from being obtained by others for improper purposes.

How You Can Get More Information about BHIX

If you have a question, ask to speak with the Privacy Officer of any Participating Provider. He or she will be able to answer your questions about BHIX or find someone who can help you. You may also email us at info@bhix.org.

For further information about BHIX, please check our website at www.bhix.org. As BHIX continues to grow, the website will include the latest listing of Health Information Sources and a complete list of Participants with contact information.

Brooklyn Health Information Exchange (BHIX)
1045 39th Street
Brooklyn, New York 11219

Fax: 718-635-5750
Telephone:718-283-5650
info@bhix.org

Form No. 9713 - Fact Sheet - English

BHIX Brooklyn Health Information Exchange

Maimonides Medical Center Brooklyn, NY 11219

Patient Consent Form for Participating Provider Organization - Maimonides Medical Center

I have received the document entitled "Brooklyn Health Information Exchange: Educational Fact Sheet" which explains how the Brooklyn Health Information Exchange ("BHIX") works, how it operates, and how I can allow medical information about me to be accessed by the hospitals, nursing homes, home health agencies and other health care providers participating in BHIX. If I sign this form as the Patient's Legal Representative, I understand that all references in this form to "me" or "my" refer to the Patient.

Each Participating Provider Organization ("Participating Provider") involved in my care must obtain my Consent separately to access my medical information through BHIX. Maimonides Medical Center is a Participating Provider in BHIX. I understand that if I Give Consent below, I hereby authorize Maimonides Medical Center, including all individuals authorized by Maimonides Medical Center to use BHIX, to access my medical information through BHIX.

9. **Purpose:** I understand that my medical information will be used only to provide me with medical treatment and to assess and improve the quality of medical care delivered by Maimonides Medical Center to its patients.
10. **Types of Information:** I understand that this Consent permits Maimonides Medical Center to access ALL of my medical information, including but not limited to, sensitive information related to the following:
    - HIV/AIDS
    - Genetic Disease or Genetic Tests
    - Sexually Transmitted Diseases
    - Mental Health
    - Alcohol or Drug Abuse Treatment
    - Family Planning
11. **Health Information Sources:** Information accessed through BHIX comes from a variety of sources ("Health Information Sources"). These Health Information Sources may include Participating Providers, other health care providers (such as pharmacies and clinical laboratories), health insurers, the New York State Medicaid program and other health information exchanges. A complete list of current Health Information Sources may be found at www.bhix.org. This list will change from time-to-time as BHIX continues to grow.
12. This Consent permits Maimonides Medical Center to access medical information created both before and after the date I sign this form. I understand that information about me may be re-disclosed by Maimonides Medical Center only to the extent permitted by applicable laws and regulations. I understand that if I Give Consent, my Consent will remain in effect until the day I withdraw consent or BHIX stops operating, whichever comes first.
13. I understand that if I change my mind and wish to withdraw consent, I can sign a Withdrawal of Consent Form. If I withdraw consent, Maimonides Medical Center will no longer be able to routinely access medical information about me through BHIX unless and until I again Give Consent by signing and completing a new Patient Consent Form. The withdrawal of consent will not affect the exchange of medical information made while my Consent was in effect.
14. I understand that if I Deny Consent below, Maimonides Medical Center will not access medical information through BHIX —even in an emergency.
15. I understand that the decision to participate in BHIX is voluntary. No Participating Provider will deny me medical care and my insurance eligibility will not be affected if I Deny Consent to participate in BHIX.
16. I understand I will get a copy of this form after I sign it.

I hereby: ☐ Give Consent ☐ Deny Consent

for Maimonides Medical Center to access ALL of my medical information from all Health Information Sources through BHIX.

Print Name of Patient	Patient's Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Patient's Legal Representative (if applicable)	Relationship of Patient's Legal Representative

Patient or Legal Representative given a copy of this form in (fill in language):_____

Translated form given to Patient or Legal Representative by:_____

Patient Copy

Maimonides
Medical Center

HUMAN RESOURCES DEPARTMENT
EMPLOYEE HEALTH SERVICE

To: Employee Health Service
Emergency Room
Outpatient Department

I hereby authorize each of the Employee Health Service, Emergency Room and Outpatient Department personnel of Maimonides Medical Center to perform routine physical and laboratory examinations (including drawing blood, PPD testing and chest X-Rays if necessary), in accordance with the Medical Center's policies; and unless notified in writing to the contrary, render and/or continue any treatment or minor surgical procedure (under local anesthesia) which may be deemed necessary for the proper care of any condition for which medical attention is requested.

_____ _____

Signature Date

_____ _____

Signature of Parent or Guardian
(If under the age of 18 (minor)) Date

Form No. 4175 (Rev. 12/08)

DEHSCONS

Maimonides
Medical Center

Maimonides Medical Center
Employee Health Services

Hepatitis B/Influenza History and Attestation

HEPATITIS B (HBV) NYS *DOH recommends health care workers receive HBV vaccination.*

Have you had HBV or been vaccinated against HBV? [ ] Yes [ ] No

Would you like to receive the HBV vaccination? [ ] Yes [ ] No

INFLUENZA VACCINATION (Recommended annually for flu season September 1 – April 1):

Did you receive your annual flu shot for the current/most recent season: [ ] Yes [ ] No

If no, please indicate why you did not get vaccinated:

- ☐ Perceived ineffectiveness of vaccine
- ☐ Medical contraindication * (Pregnancy is not considered to be a contraindication)
- ☐ Insufficient time or inconvenient
- ☐ Perceived low likelihood of contracting influenza
- ☐ Avoidance of medications
- ☐ Fear of needles
- ☐ Reliance on treatment with homeopathic medications
- ☐ Egg Allergy

Other: (please specify) _____

Would you like to receive the Influenza Vaccination? [ ] Yes [ ] No

Signature:_____ Print Name:_____

Date:_____ DOB:_____

Maimonides
Medical Center
Brooklyn, NY 11219

EFFECTIVE DATE: September 13, 2013

HIPAA 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 REVIEW IT CAREFULLY.

We are required by law to protect the privacy of your health information, and to provide you with a copy of this Notice. If you have any questions about this Notice or would like further information, please contact our Privacy Officer's Designee in the Patient Relations Department at 718 283-7212.

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the health information privacy practices of Maimonides Medical Center, its medical staff, and affiliated health care providers that jointly provide health care services with our hospital. The privacy practices described in this Notice will be followed by: (1) any health care professional who treats you at any of our locations, including our Ambulatory Health Services Network; (2) any employee, student, trainee or volunteer, at any of our locations, including our Ambulatory Health Services Network; (3) any employee, medical staff, trainee, student or volunteer at MMC Pharmacy, Inc. or Infusion Options, Inc.; and (4) any business associates of our hospital, of MMC Pharmacy, Inc. or Infusion Options, Inc. Your private physician may have different privacy practices regarding the use and disclosure of your health information related to care provided at his/her office.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient at the hospital or receiving treatment or other health-related services from our hospital;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

We explain below how we may use and disclose your health information without your written authorization.

1. **Treatment, Payment And Business Operations**

Treatment. We may share your health information with doctors, nurses, technicians or other health care providers at the hospital and its affiliated faculty practices who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor at our hospital may share your health information with another doctor inside our hospital, or with a doctor at another hospital, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care. Our different departments and health care practitioners may share your health information in order to provide and coordinate services such as prescriptions, lab work and x-rays. Our faculty, students, volunteers and trainees will have access to your health information for training and treatment purposes as they participate in continuing education training, internships and residency programs. We also may disclose health information about you to people outside the Medical Center who may be involved in your medical care after you leave the Medical Center, such as physicians who will provide follow-up care, physical therapy organizations, medical equipment suppliers, home care agencies, health homes and skilled nursing facilities.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We may share your information with other providers and payors for their payment activities, such as an ambulance company.

Business Operations. We may use your health information or share it with others in order to conduct our business operations which include internal administration, planning, and various activities that improve the quality and cost-effectiveness of the care that we deliver to you, such as performance improvement, utilization review, internal auditing, accreditation, certification, licensing, educational and credentialing activities. For example, we may use your health information to conduct patient satisfaction surveys, to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. We may disclose your health information to our patient representatives and other staff in order to resolve any complaints you may have and ensure that you have a comfortable visit with us. Finally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. To support our business operations, we may use demographic information about you, including information about your age and gender, where you live or work as well as the dates that you received treatment, the department of service, your treating physician, outcome information and your health insurance status in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want us to contact you for fundraising efforts, you may contact the Development Office at 718 283-8200.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with providing treatment or obtaining payment or carrying out our business operations. For example, we may share your health

information with a billing company that helps us to obtain payment from your insurance company. We may share your health information with medical transcriptionists and copy services which assist us with copying your medical records. If we do disclose your health information to a business associate, we will have a written contract requiring that our business associate protect the privacy of your health information.

2. **Patient Directory/Disaster Relief Organizations/Family and Friends** .

Patient Directory. If you do not object, we will include your name, your location in our facility, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation in our Patient Directory while you are a patient in the hospital or at any of our facilities. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name.

Disaster Relief Organizations. We may disclose your health information to disaster relief organizations such as the Red Cross to assist your family members or friends in locating you or learning about your general condition in the event of a disaster.

Family and Friends Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may assume you agree to our disclosure of your health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. **Public Need**

We may use your health information, and share it with others, to comply with the law or to meet important public needs that are described below.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, inspections and licensure of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a

person or company that is regulated by the Food and Drug Administration for the purpose of reporting about problems with products.

Lawsuits And Disputes. We may disclose your health information if we are ordered to by a court or administrative tribunal that is handling a lawsuit or other dispute.

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates And Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners And Funeral Directors. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. We may disclose your health information to organizations that procure or store organs, eyes or other tissues.

Research. We may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. We may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

4. **Incidental Disclosures.**
   While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

WHEN YOUR AUTHORIZATION IS REQUIRED.

Uses or disclosures of your health information for other purposes or activities, not listed above, will be made only with your written authorization. If you provide us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your authorization.

Most uses and disclosures of psychotherapy notes, uses and disclosures of health information for marketing purposes, and disclosures that constitute a sale of health information will be made only with your written authorization.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

1. **Right To Inspect And Copy Records**
   You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Health Information Services Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page and must generally be paid before or at the time we give the copies to you.

   Under certain circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a written notice that explains our reasons for denying your request, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide access to the remaining parts.

2. **Right To Amend Records**
If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to Health Information Services Department. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement, which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. **Right To An Accounting Of Disclosures**
You have a right to request an accounting of disclosures (as defined below) which identifies certain other persons or organizations to whom we have disclosed your health information. If a request for an accounting of disclosures is made to Maimonides Medical Center, our response will ordinarily be limited to disclosures made by the hospital (including our clinics) and will not usually include disclosures made by the other entities or individuals listed at the beginning of this Notice such as disclosures by individual physicians from their private offices.

An accounting of disclosures also will not include information about the following disclosures:
- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made from the patient directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers.

To request an accounting of disclosures, please write to the Health Information Services Department. Your request must state a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

4. **Right To Request Additional Privacy Protections**
You have the right to request that we further restrict the way we use and disclose your health

information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to the Health Information Services Department. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply. We will send you a written response. Except as described below, we are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. We are required to agree to your request that we not share information about a service with your health plan for payment or health care operations if you pay for the service yourself "out of pocket" in full. If we agree to a restriction, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. **Right To Request Confidential Communications**
   You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to our Patient Relations Department. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

6. **Right to Electronic Access**
   You have the right to access electronic copies of your health information when requested (to the extent that we maintain the information in an electronic form). When information is not readily producible in the electronic form and format you have requested, we will provide you the information in an alternative readable electronic format as we may mutually agree upon.

   We are advising you in this notice that, if you request that information available in an electronic format be provided via email, that email is an unsecure medium for transmitting information and that there is some risk if health information is emailed. Information transmitted via email is more likely to be intercepted by unauthorized third parties than more secure transmission channels. If we agree to email you information, you are accepting the risks we have notified you of, and you agree that we are not responsible for unauthorized access of such health information while it is in transmission to you based on your request, or when the information is delivered to you.

7. **Breach of Health Information**
   We will inform you if there is a breach of your unsecured health information.

ADDITIONAL INFORMATION

How Someone May Act On Your Behalf.
You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Please note, however, that naming someone to act on your behalf to control the privacy of your health information does not in itself give that person the right to make treatment decisions on your behalf. 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.

Special Protections For HIV-Related, Mental Health and Substance Abuse Information.
Special privacy protections apply to HIV-related information, and certain mental health information and substance abuse information. Some parts of this Notice of Privacy Practices may not apply to these types of information. A written explanation of how this information will be protected is set forth at the end of this Notice.

Privacy Officer.
Our Privacy Officer is Joyce A. Leahy, Esq. If you have any questions about this Notice or would like further information, please contact our Privacy Officer's Designee in the Patient Relations Department at 718 283-7212.

HOW TO OBTAIN COPIES OF THIS NOTICE

You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please contact the *Patient Relations Department at 718 283-7212.* You may also obtain a copy of this document from our website at www.maimonidesmed.org, or by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your information held by Maimonides and its affiliated providers and we will be required by law to abide by its terms. You will also be able to obtain your own copy of the revised notice by contacting the Patient Relations Department at 718 283-7212, accessing our website, or asking for one at the time of your next visit. The Effective Date of the Notice will be located in the upper right corner of the first page.

HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact the Patient Relations Department at 718 283-7212. No one will retaliate or take action against you for filing a complaint.

CONFIDENTIALITY OF MENTAL HEALTH INFORMATION

The privacy and confidentiality of mental health information maintained by any unit or program of this hospital that is specially licensed to provide mental health services is protected by State law and regulations. Certain types of mental health information are afforded additional protections. If there is any conflict between these protections and the protections covering other health information described above, the special protections for mental health information will apply.

Generally, personnel within the hospital (or its business associates) may use your mental health information in connection with their duties to provide you with treatment, obtain payment for that treatment, or conduct the hospital's business operations. Generally the hospital may not reveal mental health information about you to other persons outside of the hospital, *except in the following situations:*

- When the hospital has obtained your written authorization;
- To a personal representative who is authorized to make health care decisions on your behalf;
- To government agencies or private insurance companies in order to obtain payment for services we provided to you;
- To other mental health providers treating you who are part of the State's organized mental health system;
- To comply with a court order;
- To appropriate persons who are able to avert a serious and imminent threat to the health or safety of you or another person;

- To appropriate government authorities to locate a missing person or conduct a criminal investigation as permitted under Federal and State confidentiality laws;
- To other licensed hospital emergency services as permitted under Federal and State confidentiality laws;
- To the mental hygiene legal service offered by the State;
- To attorneys representing patients in an involuntary hospitalization proceeding;
- To authorized government officials for the purpose of monitoring or evaluating the quality of care provided by the hospital or its staff;
- To qualified researchers without your specific authorization when such research poses minimal risk to your privacy;
- To coroners and medical examiners to determine cause of death; and
- If you are an inmate, to a correctional facility which certifies that the information is necessary in order to provide you with health care, or in order to protect the health or safety of you or any other persons at the correctional facility.

CONFIDENTIALITY OF HIV-RELATED INFORMATION

The privacy and confidentiality of HIV-related information maintained by Maimonides Medical Center is protected by Federal and State law and regulations. These protections are more extensive than the protections for your other health care information described above.

Confidential HIV-related information is any information indicating that you had an HIV-related test, have HIV-related illness or AIDS, or have an HIV-related infection, as well as any information which could reasonably identify you as a person who has had a test or has HIV infection.

Under New York State law, confidential HIV-related information can only be given to persons allowed to have it by law, or persons you have allowed to have it by signing a written authorization form.

In general, confidential HIV-related information about you may be used by personnel within the hospital who need the information to provide you with direct care or treatment, to process billing or reimbursement records, or to monitor or evaluate the quality of care provided at the hospital. Generally the hospital may not reveal to a person outside of the hospital any confidential HIV-related information that the hospital obtains in the course of treating you, *unless:*

- The hospital obtains your written authorization;
- The disclosure is to a person who is authorized under applicable law to make health care decisions on your behalf and the information disclosed is relevant to that person fulfilling such health care decision making role;
- The disclosure is to another health care provider or payer for treatment or payment purposes;
- The disclosure is to an external agent of the hospital who needs the information to provide you with direct care or treatment, to process billing or reimbursement records, or to monitor or evaluate the quality of care provided at the hospital. In such cases, the hospital will ordinarily have an agreement with the agent to ensure that your confidential HIV-related information is protected as required under Federal and State confidentiality laws and regulations;
- The disclosure is required by law or court order;
- The disclosure is to an organization that procures body parts for transplantation;
- You receive services under a program monitored or supervised by a Federal, State or local government agency and the disclosure is made to such government agency or other employee or agent of the agency when reasonably necessary for the supervision, monitoring, administration of provision of the program's services;
- The hospital is required under Federal or State law to make the disclosure to a public health officer, including the required reporting of certain test results and known contacts;
- The disclosure is required for public health purposes and/or in connection with certain exposure incidents with Medical Center staff;

- If you are an inmate at a correctional facility and disclosure of confidential HIV-related information to the medical director of such facility is necessary for the director to carry out his or her functions;
- For decedents, the disclosure is made to a funeral director who has taken charge of the decedent's remains and who has access in the ordinary course of business to confidential HIV-related information on the decedent's death certificate;
- The disclosure is made to report child abuse or neglect to appropriate State or local authorities.

Violation of these privacy regulations may subject the hospital to civil or criminal penalties. Suspected violations may be reported to appropriate authorities in accordance with Federal and State law.

HOW TO FILE A COMPLAINT CONCERNING USE OF YOUR HIV-RELATED INFORMATION

If you experience discrimination because of the release of confidential HIV-related information, you may contact the New York State Division of Human Rights at 888.392.3644 or the New York City Commission of Human Rights at 212.306.7500. These agencies are responsible for protecting your rights.

Maimonides
Medical Center
Brooklyn, NY 11219

ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices (in my preferred language, if available) and have therefore been advised of how health information about me (and, if applicable, about any infant(s) to whom I gave birth during my admission to Maimonides MedicalCenterl) may be used and disclosed by the hospital and the facilities listed at the beginning of this Notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate written explanations of special privacy protections that apply to HIV-related information and mental health information.

_____ _____
Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____/_____/_____ _____
Date Description of Personal Representative's Authority

Patient or Personal Representative given a copy in (fill in language)_____

Translated "Notice of Privacy Practices" given to Patient or Personal Representative by: _____

* *

(For internal use or where signature above cannot be obtained)

Except in emergency treatment circumstances, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices on the first date after April 14, 2003 we provide treatment, products or services to the patient (including at the time of admission, at a first visit to a hospital department, or any other first service contact with the patient). We must make a good faith effort to obtain written acknowledgment when reasonably practicable following an emergency treatment situation. If such acknowledgment cannot be obtained, we must document our good faith efforts to obtain the acknowledgment and why it was not obtained.

Describe good faith efforts to obtain written acknowledgment **(include your name and the date):**

1. ☐ Patient unable to sign due to medical condition(s) ☐ Patient refused to sign

   Name:_____ Date:_____

2. ☐ Patient unable to sign due to medical condition(s) ☐ Patient refused to sign

   Name:_____ Date:_____

3. ☐ Patient unable to sign due to medical condition(s) ☐ Patient refused to sign

   Name:_____ Date:_____

THE ORIGINAL OF THIS FORM MUST BE PLACED IN THE MEDICAL RECORD

Revised 09/09

DHIPAA